



3 1761 11651490 2

RB19186



Library
of the
University of Toronto

HANDBOUND
AT THE



UNIVERSITY OF
TORONTO PRESS

CA/
Z 1
-61H21


Government
Publications

cage

Canada. Royal commission on health
services.

Hearings, v. 51-53, 1962.

1964



Digitized by the Internet Archive
in 2023 with funding from
University of Toronto

<https://archive.org/details/31761116514902>

ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

TORONTO

ONT.

VOLUME NUMBER :

51

DATE :

MAY 11 1962

v. 51 Briefs 261 - 268
v. 52 Briefs 269 - 277
v. 53 Briefs 278 - 279



OFFICIAL REPORTERS
ANGUS, STONEHOUSE & CO. LTD.
BOARD OF TRADE BLDG.
11 ADELAIDE ST. W.
TORONTO

364-5865

364-7383



ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings
held in Toronto, Ontario,
on the 11th day of May, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

MISS ALICE GIRARD, R. N.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

MR. M. WALLACE McCUTCHEON, Q.C.

PROF. O. J. FIRESTONE

DR. DAVID M. BALTZAN

COMMISSION COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

COMMISSION SECRETARY:

MR. N. LAFRANCE



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

VOLUME 51

INDEX TO SUBMISSIONS

Page No.

BOARD OF EXAMINERS IN OPTOMETRY, PROVINCE OF ONTARIO	9621
OPTOMETRICAL ASSOCIATION OF ONTARIO	9677
CANADIAN OPHTHALMOLOGICAL SOCIETY	9701
VICTORIAN ORDER OF NURSES (ONTARIO)	9727
VICTORIAN ORDER OF NURSES FOR CANADA	9755
ASSOCIATION OF CANADIAN MEDICAL COLLEGES	9786
THE CONNAUGHT LABORATORIES, UNIVERSITY OF TORONTO	9820



1
2
3 ---On resuming at 9:30 a.m.
4

5 THE SECRETARY: Mr. Chairman, today's
6 first presentation will be the Board of Examiners in
7 Optometry for the Province of Ontario. Mr. Baker will
8 introduce the members of his group and the submission
9 will be known as Exhibit number 261.

10 ---EXHIBIT NO. 261: Submission of the
11 Board of Examiners in
12 Optometry.

13 SUBMISSION OF
14 THE BOARD OF EXAMINERS IN OPTOMETRY
15 FOR THE PROVINCE OF ONTARIO

16 THE CHAIRMAN: Thank you. Mr. Baker?

17 MR. BAKER: Thank you. Good morning.
18 I would first like to introduce myself Mr. Chairman.
19 I am Irving Baker, practising optometrist in the City
20 of Toronto and I am one of five members of the Board
21 of Examiners in Optometry.

22 I would like to introduce our delega-
23 tion to you sir. On my far right is Donald L. Lamont,
24 who is the solicitor to the Board of Examiners in this
25 Province. Next is Edward J. Fisher, who is the Dean
26 of the College of Optometry of Ontario, and then Marvin
27 A. Langer, who is a practising optometrist in the City
28 of Toronto and a member of the staff of the College.

29 On my left is Clare W. Bobier, who is
30 a member of the staff of the College. With your per-
mission, sir, I would like to read the summary and



Baker

9622

conclusions of our submission.

THE CHAIRMAN: May we invite you to sit down, sir?

MR. BAKER: Thank you.

The Board of Examiners in Optometry for the Province of Ontario presents in this submission the problems in optometrical education and in the training of an adequate number of optometrists to meet the future requirements of the people of Canada for vision care.

The conclusions and recommendations arising from this submission are discussed under three headings:

A. The Provision of Adequate Numbers of Optometrists.

B. Means for Ensuring That Optometrical Personnel Have Adequate Training and Qualifications.

C. Financial Considerations.

CONCLUSIONS arising from this submission are the following:

In order to provide an adequate number of optometrists the following are necessary:

A. The Provision of Adequate Numbers of Optometrists:

(i) To maintain the present ratio of optometrists to population there must be an increase in numbers of optometrists of 21% by 1970 and 50% by 1980.

(ii) To provide for this increased number of optometrists and for the replacement of those lost through attrition the colleges will require a student



body more than twice its present size by 1965 and more than three times by 1980.

(iii) The past two years have shown increased enrolments. While this trend is encouraging it appears that present methods of recruitment will not attract sufficient numbers of students to meet these projected needs.

(iv) Immediate expansion of the physical facilities of the College of Optometry of Ontario is necessary to accommodate its share of these larger enrolments. A capital expenditure of approximately \$500,000.00 is required.

B. Means for Ensuring That Optometrical
Personnel Have Adequate Training
and Qualifications:

(v) Optometrical education is designed to provide a broad background in the basic sciences and the special sciences related to vision, and to develop the professional skills and the sense of responsibility necessary for the practice of the profession of optometry.

(vi) The College program must provide for under-graduate training, graduate training, post-graduate training and research.

(vii) To maintain teaching standards and encourage research, graduate training leading to higher degrees is necessary. At the present time graduate training in optometry is available in the graduate schools of several universities in the United States. Graduate training in optometry is not available in Canada.



(viii) Research affords new knowledge and provides an important intellectual stimulus to education. More research in vision should be undertaken in Canada. The basic and applied research programs at the College should be expanded.

(ix) In order to ensure the success of all four phases of this program an adequate number of teaching personnel with suitable training and qualifications must be available. The present staff of the College needs to be increased.

The conclusions regarding financial considerations are as follows:

(x) At the present time the College of Optometry of Ontario has two sources of income -- tuition fees and funds supplied by the Board of Examiners in Optometry.

(xi) Tuition fees account for somewhat less than 30% of the current operating costs of the College. The balance of these costs is paid by the Board of Examiners. This revenue is obtained from practising optometrists in the Province of Ontario as annual registration fees.

(xii) The College does not receive provincial or federal grants in support of optometrical education.

(xiii) It is estimated that in 1965 the operating deficit will be three times its present amount. Present methods of financing can not meet this deficit. Additional sources of revenue are necessary.

The following recommendations arise from this submission:



A. To Provide Adequate Numbers of Optometrists
Requires:

(I) That the Royal Commission on Health Services investigate or appoint a committee to investigate and recommend ways and means of encouraging students with satisfactory qualifications to enter the professions.

(II) That Optometry's present student recruitment program be supplemented by making available and by increasing the number of bursaries, scholarships and loans to optometry students.

(III) That the present facilities of the College of Optometry of Ontario be expanded immediately.

(IV) That a third school of optometry be established in Canada.

B. In Order To Ensure That Adequate Numbers of
Optometrical Personnel Have Adequate Training
and Qualifications Requires:

(V) That fellowships and grants for graduate training of optometrists be made available in order to provide for the necessary research and teaching personnel.

(VI) That a graduate school be established at or in association with the College of Optometry of Ontario.

(VII) That an Associate Committee on Optometrical Research be established by the National Research Council to advise the Council concerning research grants to optometry.



(VIII) That research in vision should be stimulated through the utilization of additional optometrists in such federal departments as:

The Department of Veterans Affairs

The Department of National Health and Welfare

The Department of National Defence

The Department of Northern Affairs and National Resources

The Department of Citizenship and Immigration

(IX) That research in vision should be stimulated through the utilization of optometrists in the Provincial Public Health Programs.

C. To Finance Optometrical Education Requires:

(X) That the federal and provincial governments provide grants to the College of Optometry of Ontario to support undergraduate education.

(XI) That the National Research Council and the Department of National Health and Welfare provide fellowships and grants to optometrists for graduate education.

(XII) That an immediate capital grant be provided for the necessary expansion of the facilities of the College of Optometry of Ontario.

Over the past 50 years the universities have assumed an increasing responsibility in the training of members of the health professions in Canada. Training within the university has become the accepted way of ensuring high standards of academic attainment and professional qualification.



Baker

9627

1
2
3
4 That the governments of Canada have
5 recognized the effectiveness of this system is apparent
6 by the legislative measures which have been enacted to
7 enhance and facilitate this operation.

8 Since the requirements of optometrical
9 education do not differ from those of the other
10 health professions, it is the opinion of the Board that
11 inclusion of the College of Optometry of Ontario in this
12 system would, in the long run, serve the best interest
13 of the public and the profession.

14 Thank you, Mr. Chairman.

15 THE CHAIRMAN: Thank you Mr. Baker.
16 Now is there anyone else with you here this morning
17 who wishes to add to what you say, or do you yourself
18 wish to expand on your summary and recommendations at
19 this time, or any of your associates?

20 MR. BAKER: I think we have said
21 enough, sir, for the time.

22 THE CHAIRMAN: In regards to the
23 status of the College in Ontario, I judge from your
24 recommendation on page 5, last three paragraphs on page
25 5, that you are completely detached from any university
26 centre. Is that correct?

27 MR. BAKER: That is correct sir.

28 COMMISSIONER McCUTCHEON: Why is that
29 Mr. Baker? I mean what led to that decision because I
30 see under the Act ---

THE CHAIRMAN: I was just going to
refer to Section 9 of the Act.

MR. BAKER: I think it may be answered

That the governments of Canada have
recognized the effectiveness of this system in securing
by the legislative measures which have been enacted to
enhance and facilitate this operation.

Since the requirements of botanical
education do not differ from those of the other
health professions, it is the opinion of the Board that
the union of the College of Botany of Ontario in this
system would, in the long run, serve the best interest
of the public and the profession.

Thank you, Mr. Chairman.

THE CHAIRMAN: Thank you Mr. Barker.

Now is there anyone else with you this morning
who wishes to add to what you say, or do you yourself
wish to expand on your summary and recommendations as
this is one of your associations?

MR. BARKER: I think we have said

everything, sir, for the time.

THE CHAIRMAN: In regards to the

status of the College in Ontario, I find from your
documentation on page 5, last three paragraphs on page
5, that you are completely detached from any university
and you are your own body.

MR. BARKER: That is correct sir.

THE CHAIRMAN: Now is there

any other person who wishes to add to what you have said?

THE CHAIRMAN: I see that person is

not here (looking at the list).

MR. BARKER: I think I may be permitted



1
2
3
4 best this way: This College, as our submission has
5 indicated, was first developed in 1925, and at that
6 time, for many reasons I believe, it was felt that
7 to develop outside of the university was perhaps a
8 desirable thing.

9 THE CHAIRMAN: That was the view of
10 the College?

11 MR. BAKER: It's difficult for me to
12 say. I am not sure. This is my impression. In some
13 respects this doesn't, as I understand it, differ too
14 much from many of the professional schools of this
15 time.

16 My understanding is that many pro-
17 fessional schools in this era, and just prior to this
18 era did develop outside of the universities.

19 The fact of the matter is that in the
20 last 25 years all of the optometric institutions which
21 have developed in the United States and in Mexico,
22 Australia, have all been within the University. This
23 Board is of the opinion that our stage of development
24 has been reached whereby university affiliation is now
25 the most desirable way of continuing not only for
26 ourselves but in order to provide those facilities that
27 are necessary for training adequate numbers and adequately
28 trained people, as we have indicated in our submission,
29 to meet the needs of the Canadian public and to that
30 end we are working.



best this way: This College, as our suggestion has indicated, was first developed in 1925, and at that time, for many reasons I believe, it was felt that to develop outside of the university was perhaps a

THE CHAIRMAN: That was the view of

the college?

MR. BAKER: It's difficult for me to say. I am not sure. This is my impression. In some respects it doesn't, as I understand it, differ too much from many of the professional schools of this time.

My understanding is that many professional schools in this era, and just prior to this era did develop outside of the universities.

The fact of the matter is that in the last 25 years all of the optometric institutions which have developed in the United States and in Mexico, Australia, have all been within the University. This is of the opinion that our stage of development has been reached whereby university affiliation is now

the most desirable way of continuing not only for our own but in order to provide those facilities that are necessary for training adequate numbers and adequately trained people, as we have indicated in our suggestion, to meet the needs of the Canadian public and to that end we are working.



1
2
3
4 COMMISSIONER McCUTCHEON: What do you
5 mean you are working?

6 MR. BAKER: Well, this is one of the
7 areas which the Board had the most difficulty with in this
8 submission. As you recognize, or may not, there are
9 current negotiations going on, and while we can talk for
10 ourselves in terms of what our needs are, it does involve
11 a number of other groups, such as universities, the
12 Government of the Province, and perhaps to some extent the
13 profession of ophthalmology. We felt that since the
14 negotiations are current the exposure of the details of
15 these things at this time would be untimely.

16 I would like to stress, however, that
17 any problems that are here tend to be of a local nature.
18 As you are aware in our submission, the school in Montreal
19 is affiliated with the University of Montreal; more than
20 half of the schools in the United States are affiliated
21 with the universities; there is a recent one in Mexico
22 that is affiliated with the university, and there is a
23 new one in Australia which is affiliated.

24 THE CHAIRMAN: Is Montreal the only
25 one?

26 MR. BAKER: There are only the two in
27 Canada.

28 COMMISSIONER McCUTCHEON: If your
29 negotiations are successful then, we will be absolved from
30 dealing with the recommendation.

MR. BAKER: To an extent. But we would
certainly wish that you would make the recommendation that
it be affiliated.

1955

COMMISSIONER MONTGOMERY: What do you

mean you are working?

MR. BAKER: Well, this is one of the

areas which the Board had the most difficulty with in this

submission. As you recognize, or may not, there are

current negotiations going on, and while we can talk for

ourselves in terms of what our needs are, it does involve

a number of other groups, such as universities, the

Government of the Province, and perhaps to some extent the

profession of anthropology. We felt that since the

negotiations are current the exposure of the details of

these things at this time would be untimely.

I would like to stress, however, that

any problems that are here tend to be of a local nature.

As you are aware in our submission, the school in Montreal

is affiliated with the University of Montreal; more than

half of the schools in the United States are affiliated

with the universities; there is a recent one in Mexico

that is affiliated with the university, and there is a

one in Australia which is affiliated.

THE CHAIRMAN: Is Montreal the only

one?

MR. BAKER: There are only two in

Canada.

COMMISSIONER MONTGOMERY: If you

negotiations are successful then, we will be able to

deal with the recommendation.

MR. BAKER: To an extent, but we would

certainly wish that you would make the recommendation that

the



Baker 9630

COMMISSIONER VAN WART: You are not affiliated with the University of Toronto.

MR. BAKER: That is correct, sir.

COMMISSIONER VAN WART: And you recommend that a third school be established in Canada.

MR. BAKER: Yes.

COMMISSIONER VAN WART: What part of Canada do you have in mind?

MR. BAKER: We have opinions, and as our opinion is being asked, in order to ensure the supply, etcetera, of optometrists as well as to create perhaps more academic competition, which is good for the field, and in thinking in terms of the cost factor, mostly at the under-graduate level, our feeling is that it should be located in Western Canada.

COMMISSIONER VAN WART: Is it your thinking that that school would be affiliated with the university, say, Montreal?

MR. BAKER: The answer would be yes. For example, a few years ago --- the date escapes me --- some negotiations were carried on between the Saskatchewan Optometric Association and the University of Saskatchewan, and it was approximately in 1948, and at that time the University of Saskatchewan not recommended but agreed it was a fit discipline to be taught at that school. I don't know why the negotiations were not finally completed, but it would probably be in the area of financial need at the moment.

COMMISSIONER STRACHAN: Are your recommendations in order of high priority, or would you

COMMISSIONER VAN WART: You are not

affiliated with the University of Toronto.

MR. BAKER: That is correct, sir.

COMMISSIONER VAN WART: And you recommend

that a third school be established in Canada.

MR. BAKER: Yes.

COMMISSIONER VAN WART: What part of

Canada do you have in mind?

MR. BAKER: We have opinions, and as

our opinion is being asked, in order to ensure the supply

of optometrists, of optometrists as well as to create perhaps

more academic competition, which is good for the field,

and in thinking in terms of the cost factor, mostly at

the undergraduate level, our feeling is that it should

be located in Western Canada.

COMMISSIONER VAN WART: Is it your

thinking that that school would be affiliated with the

University, say, Montreal?

MR. BAKER: The answer would be yes.

For example, a few years ago --- the date escapes me ---

some negotiations were carried on between the Saskatchewan

Optometric Association and the University of Saskatchewan,

and it was approximately in 1948, and at that time the

University of Saskatchewan not recommended but agreed it

was a fit discipline to be taught at that school. I don't

know why the negotiations were not finally completed, but

it would probably be in the area of financial need at

the moment.

recommendations in order of high priority, or would you



Baker 9631

sooner see the present ones extended before a third one was established?

MR. BAKER: As I see it, the present facilities should be made optimum use of and exploit the full use of the facilities of the university currently.

COMMISSIONER STRACHAN: Are you saying that the present facilities be expanded before you have school accommodation here?

MR. BAKER: I would say that the answer to the question is that it would have to be so until we have the thing financed completely with all staff, etcetera.

MR. LANGER: I would expand by saying that it would be necessary in order to meet the projected enrolments that the order of priority would be to meet undergraduate training. With respect to graduate training, such training can be obtained at outside universities, and while the problem is important, it is not as urgent as the undergraduate problem.

COMMISSIONER BALTZAN: How is this school financed?

MR. BAKER: The school, sir, is financed from tuition and registration fees of the optometrists in Ontario, and under the Act we have provisions --- it is quoted in the submission. What happens is that our tuition fees are applied to our costs as well as the money obtained from all of the optometrists in the Province. As a matter of fact, we are rather proud of the fact that we have been able to, through our own efforts, through the profession's efforts, maintain an



10-11-41

...see the present ones enter or before a time one
was established

MR. BAKER: As I see it, the present

facilities should be made optimum use of and exploit the
full use of the facilities of the university currently.

COMMISSIONER STRACHAN: Are you saying

that the present facilities be expanded before you have
school accommodation here?

MR. BAKER: I would say that the

answer to the question is that it would have to be so

until we have the thing financed completely with all

start, etcetera.

MR. LANGER: I would expand by saying,

that it would be necessary in order to meet the projected

increments that the order of priority would be to meet

undergraduate training. With respect to graduate training,

both training can be obtained at outside universities,

and while the problem is important, it is not as urgent

as the undergraduate problem.

COMMISSIONER BALTMAN: How is this

school financed?

MR. BAKER: The school, sir, is financed

from tuition and registration fees of the students

in Ontario, and under the Act we have provisions --- it

is quoted in the submission. What happens is that our

tuition fees are applied to our costs as well as the

amounts obtained from all of the students in the

province. As a matter of fact, we are rather proud of

the fact that we have been able to, through our own

efforts, through the government's efforts, maintain a



Baker 9632

institution of this size and calibre. This is, if I may use a common term, a very good do-it-yourself effort. We are very proud of our institution, and the men in this Province to some extent are financing Canadian optometry, that is providing the optometrists to meet the needs throughout Canada, and they are providing it quite willingly.

COMMISSIONER VAN WART: How much is the licence fee?

MR. BAKER: The current licence fee is \$60.00, and of course, there are other fees involved, such as the professional associations. They are over and above this.

THE CHAIRMAN: Does your college participate in the university grants?

MR. BAKER: No, sir.

THE CHAIRMAN: You referred to the application made to the University of Saskatchewan in 1948. I think Mr. Arnold was on the Senate at that time. I think we were on the committee together which dealt with it. Has it been removed since that time?

MR. BAKER: It may be more proper to ask Mr. Arnold. I do not have this information, sir.

MR. ARNOLD: No, it hasn't.

THE CHAIRMAN: As I recall, I think at that time the numbers which might have been expected were not sufficient to warrant setting it up.

MR. LANGER: I think, sir, this has probably been often a consideration in the past, that if the College of Optometry in Ontario has constituted what

institution of this size and calibre. This is, I think, a very good do-it-yourself effort. We are very proud of our institution, and the fact is that we are very proud of our institution, and the fact is that we are very proud of our institution. We are very proud of our institution, and the fact is that we are very proud of our institution. We are very proud of our institution, and the fact is that we are very proud of our institution.

THE CHAIRMAN: Now, what is the licence fee? MR. BAKER: The licence fee is \$60.00, and of course, there are other fees involved, such as the professional associations. They are not as high as some of the other professions.

THE CHAIRMAN: Does your college participate in the university grants? MR. BAKER: Yes, sir. THE CHAIRMAN: You referred to the application made to the University of Saskatchewan in 1948. I think Mr. Arnold was on the Senate at that time. I think we were on the committee together which dealt with it. Has it been removed since that time?

MR. BAKER: It may be more proper to ask Mr. Arnold. I do not have this information, sir. MR. ARNOLD: No, it wasn't.

THE CHAIRMAN: As I recall, I think at that time the papers which might have been expected were not sufficient to warrant setting it up. MR. BAKER: I think, sir, that it is probably been often a consideration in the past, that the College of Agriculture in Canada has been considered as



Langer 9633

would be a small faculty and it would appear from the projections to meet the needs in the future, that this will change, and I think therefore, that in the process of achieving success in optometric education and in meeting the needs we are facing some of the problems and we are no longer as an institution able to finance the requirements we were able to in the past, because of the small numbers involved it was possible to do so.

COMMISSIONER McCUTCHEON: You have preserved a measure of independence which you are about to abdicate.

MR. LANGER: Yes. I think this is the reason of a new profession, a desire to grow outside established institutions, and it permits a rate of growth which is a little faster.

MR. FISHER: May I add that there is a certain amount of inertia in the discussions that have been held regarding university affiliation, and it would be helpful if the Commission recommended that it be achieved.

COMMISSIONER McCUTCHEON: This would be rather a difficult recommendation for the Commission to make.

MR. FISHER: Well, possibly.

THE CHAIRMAN: These matters are so fundamental within the university sphere of activity in a sense and within the powers of the Province as distinct from the Dominion, Parliament.

MR. BAKER: We recognize this, sir, but the problem, I think, that faces us is if the public



Baker 9634

1
2
3
4 need is to be met, then --- I think we have tried to
5 make this very clear in our submission --- that optometry
6 cannot be called upon to finance its own education if
7 the numbers of optometrists to be produced to meet these
8 needs are going to be successfully met, and in this
9 context is the context of why we ask for this type of
10 recommendation. We have now reached the point where we
11 are on the verge of where we can continue as we are,
12 but this would not meet the needs of the actual interests
13 you have in the future.

14 THE CHAIRMAN: Your first recommendation
15 on Page 4, under A:

16 "That the Royal Commission on Health
17 Services investigate or appoint a committee to
18 investigate and recommend ways and means of encour-
19 aging students with satisfactory qualifications to
20 enter the professions."

21 I think it is quite in order for us
22 to tell you that we have such studies and they are being
23 done, and particularly insofar as optometry is concerned
24 it is being done by a scholar of the Department of Labour.
25 It is one of the studies that are being done for the
26 Commission at the moment.

27 MR. BAKER: Thank you very much for the
28 information, sir.

29 MR. LANGER: One of the problems we
30 have to face, of course, is if we are successful in
creating the students to meet the need we are creating new
problems for our institution. In other words, if we are
able to attract sufficient students to meet the needs for



Baker 9635

Canada we are placing ourselves in a financial position where we are unable to finance their education. So on the one hand we are having, in order to meet the need of optometrists in Canada, to attract new students to the profession; and, on the other hand, we have the problem, if we are successful in so doing, we create financial problems which are very difficult. And certainly as to finances, whether within the university or as a separate institution, as at present, there is a need for it to be in the system of Canada.

COMMISSIONER McCUTCHEON: What is the situation in Quebec?

MR. BAKER: The situation in Quebec, as we understand it, simply means that instead of a graduate of this college --- my understanding is that graduates from any other college other than the one in Quebec, instead of being licensed immediately upon examination must attend the University of Montreal one month prior to attending the examination. If a student comes from an accredited optometric institution the Board of Examiners will allow this new graduate to sit the Board examination.

COMMISSIONER McCUTCHEON: Your college is an accredited institution?

MR. BAKER: Yes.

COMMISSIONER McCUTCHEON: Is the one in Montreal an accredited institution?

MR. BAKER: I believe so, sir. I would ask Mr. Fisher to answer that. I am not sure.

MR. FISHER: I am not sure about the



Fisher 9636

status of the school at Montreal. I believe it is not accredited.

COMMISSIONER McCUTCHEON: There is no accrediting agency in Canada.

MR. BAKER: That is correct, sir.

THE CHAIRMAN: You are recommending graduate and post-graduate studies.

MR. BAKER: Yes, sir.

THE CHAIRMAN: To what level do you think that these should go?

MR. BAKER: Well, we feel ultimately they should go to the Ph.D. level as intimated in our submission. We have now two graduates of our college attending the University of Indiana on Ph.D. programs, and we hope we will be able to entice them back there.



Baker

9637

THE CHAIRMAN: Well now, this may be a layman's simple approach; as you have post-graduate and extended post-graduate studies in optometry, does there come a point where you merge with ophthalmologists?

MR. BAKER: No sir, not at all.

THE CHAIRMAN: I wonder why?

MR. BAKER: It is not in the area of medical training. We do not suggest we are medically trained in this regard. Our graduate programs, and I would like to distinguish the two; we do not have any, what we would call, specialties within the field of optometry. Our post-graduate programs that are offered are offered to men who are in practice and they vary in length as indicated by our submission and vary mostly clinically in nature. The graduate program usually applies to the young man who has come out into the field who perhaps wants to make a career of either research or teaching and the graduate training that he takes is mostly in the area of what we call physiological optics which is basic optometry and it is a matter of depth rather than extension.

COMMISSIONER FIRESTONE: Mr. Baker, in your conclusions under paragraph A, sub-paragraph I, you say:

"To maintain the present ratio of optometrists to population there must be an increase in numbers of optometrists of 21% by 1970 and 50% by 1980."

Is the present ratio of optometrists to



Baker

9638

population adequate?

MR. BAKER: I think we can give an opinion on this, sir. I would say that with the exception of, perhaps, Newfoundland and some of the eastern provinces, some of the other eastern provinces and taking out the localized situation of distribution that developed, I would say that in general the present number of optometrists in the field are adequate.

COMMISSIONER FIRESTONE: If a comprehensive medical care insurance program were introduced in Canada would you expect that the demand for services of optometrists would increase?

MR. BAKER: If there was a comprehensive health care program including optometry, if we can go by the experience of the national health services, the answer to the question would be yes, there would be a substantial increase in demand initially and then we would think it would flatten out and probably run at about 13% or some percent per annum.

COMMISSIONER FIRESTONE: If such a health care program were introduced would you feel that the projections which you have included in paragraph A, sub-paragraph I, would be adequate to take care of this increased service demanded?

MR. BAKER: That is a difficult question to answer. I would think there might be an initial crisis but beyond this I would not be sure. I must be honest about this, I really do not know. I think the demand might be greater than the supply initially but I suspect it would tend to flatten out.



Baker

9639

1
2
3
4 COMMISSIONER FIRESTONE: May I now turn
5 to your recommendations on page IV, sub-paragraph 2,
6 in which you recommend that an increasing number of
7 bursaries, scholarships and loans be offered to students.
8 I take it these are recommendations for bursaries,
9 scholarships and loans to both under-graduate and graduate
10 students?

11 MR. BAKER: I think I will refer that
12 question over to our man of finance.

13 MR. LANGER: Yes, although we have made
14 a separate recommendation with respect to graduate
15 training under Section C.

16 COMMISSIONER FIRESTONE: Yes, I have
17 noticed that. My question is, if you have a recommenda-
18 tion for such bursaries and scholarships would you care
19 to suggest to us what would be an appropriate amount
20 separately for the undergraduate and separately for the
21 graduate?

22 MR. LANGER: Well, with respect to the
23 undergraduate students, our feeling is that the desired
24 goal of bursaries and scholarships, in particular, is
25 that they should remove any financial barriers to
26 students having the proper capabilities receiving an
27 education in optometry. My feeling would be that it is
28 most difficult to establish a set amount and that likely
29 a sliding scale which is gauged to the need of the student
30 would be more appropriate. In other words, there may be
some students who require just a small amount of financial
assistance in order to make it possible and other students
with good qualifications who may require more than just



Langer

9640

tuition fees, for instance.

Of course, a great deal would depend on the financial resources of the community to make this available, obviously, and present bursaries provided by the Board of Examiners are in the amount of \$475 which covers tuition fee. With respect to graduate education we have considered that a fellowship of \$1,500 per year plus tuition fee would make it possible for more students to avail themselves of such graduate education.

COMMISSIONER FIRESTONE: If I were to add to what you have suggested, as a fee for studies, about \$500, do I understand your recommendation would be for graduate scholarships of \$2,000 a year for graduate students per year?

MR. LANGER: Yes, sir.

COMMISSIONER FIRESTONE: Including fees?

MR. LANGER: The cost of graduate education varies with the university which is providing it. Very often tuition fees in graduate schools is nominal. I am afraid offhand I could not give you an exact amount but I would think \$2,000 would not be too little, generally speaking.

COMMISSIONER FIRESTONE: In other words, not too little you consider to be adequate?

MR. LANGER: Yes.

COMMISSIONER FIRESTONE: That would be for graduate students, \$1,000 or \$1,500 including fees as well as living expenses, would be adequate for undergraduates?

MR. LANGER: Well, if we are assuming,



Langer

9641

of course, that there is no financial ability on the part of the student to meet any of the costs. Generally speaking, we find that the cost of living for an academic year runs in the neighbourhood of \$1,000 to \$1,100 and since we provide education for students coming from all parts of Canada there is the added problem, sometimes, of transportation costs.

COMMISSIONER McCUTCHEON: I like your original assumption. Sometimes as you sit here for a period of days you wonder why the universities are not completely closed, why anybody can come.

MR. LANGER: We are not proposing that the immediate need is that bursaries be provided to all students.

COMMISSIONER FIRESTONE: We were really discussing at the moment the amounts and we will come to the numbers in a minute. Do I understand you consider a bursary or scholarship to undergraduate students in the order of \$1,000 to \$1,500 adequate?

MR. LANGER: Yes, sir.

COMMISSIONER FIRESTONE: Is the implication of your recommendation that such scholarships should be made available by the Federal Government?

MR. LANGER: In the case of optometry I think that in our situation where education is provided at this institution for students throughout Canada that this certainly might be considered although I would think that there is certainly provincial responsibility in this matter.

COMMISSIONER FIRESTONE: What you are



Langer

9642

suggesting is, you would welcome scholarships both from the Federal and Provincial Governments, is that right?

MR. LANGER: Certainly, sir.

COMMISSIONER FIRESTONE: You appreciate this Commission is advising the Federal Government, not the Provincial Government and may we have an indication of how many scholarships you would expect at the undergraduate and graduate level from the Federal Government per year?

MR. LANGER: I can answer the question with regard to the graduate level much more readily. Well, first from the graduate level, at the moment I would think two such fellowships would cover the immediate need as far as our College of Optometry is concerned. I cannot speak for the University of Montreal but I would think their needs are similar.

COMMISSIONER FIRESTONE: In other words, four would apparently meet the needs of both?

MR. LANGER: I would think so, sir.

COMMISSIONER FIRESTONE: Can we have some guidance on the undergraduate level?

MR. BAKER: I will try to answer that question. I think the answer to the question is, I think it is my feeling that a student who has adequate academic background and wants to pursue his higher education should not be prevented from doing so for lack of funds.

Now, how many people fall into this category I personally do not know and at this I would like to leave it unless the Dean has some suggestion as



Baker

9643

to the number that might be considered adequate at the moment.

COMMISSIONER FIRESTONE: Presumably you may want to arrive at such a figure on a trial and error basis in trying to suggest a small number at the beginning and if there is further demand you may want to increase the number depending on experience. However, you have to make a start and we are coming to you for advice on what you really mean in this recommendation. What is the starting point? Would you suggest 10 or 15 such scholarships?

DEAN FISHER: Possibly one from each province would be a good starting point.

COMMISSIONER FIRESTONE: In other words, you suggest 10 as a start without tying it to each province or would you leave it open?

DEAN FISHER: It probably would be better left open because some of the smaller provinces may not require it.

COMMISSIONER FIRESTONE: I think that answers my question.

COMMISSIONER VAN WART: May I ask a question along that line? Is it your idea that these scholarships be repayable or are they outright grants?

MR. BAKER: I think this is a matter we have not given serious consideration to and I can express no more than a personal opinion. My first impulse is to say they should be repayable but I do not know the full implications of that remark. I think I must say, and I am looking across the table here, that we really



Baker

9644

have not considered that at all.

COMMISSIONER VAN WART: To be repayable
it could be used for a long-term scholarship fund?

MR. BAKER: Yes, sir. As a matter of
fact, the College of Optometry, at the present time -
we do have a loan fund which has been created by the
profession in Canada which supplies certain students
with funds to make their education possible and they
pay it back; it is a non-interest loan.



B/hm

9645

1
2
3
4 COMMISSIONER FIRESTONE: I recall that
5 in your paragraph 8, sub-paragraph 2 you speak of
6 recommending both scholarships and loans, so presumably
7 the two things are not inclusive, but they are
8 complimentary.

9 MR. LANGER: Yes, scholarships
10 generally are based on academic achievement and loans
11 are available to those who don't qualify on that
12 basis.

13 COMMISSIONER FIRESTONE: Thank you
14 very much. My next question relates to paragraph VIII
15 -- paragraph (b) on IV where you speak of research be
16 stimulated in various government departments in the
17 field of optometry. Is there research being carried on
18 now?

19 MR. BAKER: By optometry?

20 COMMISSIONER FIRESTONE: By the
21 departments listed in paragraph VIII on page IV.

22 MR. LANGER: To our knowledge the
23 answer to that question would be, substantially, no.

24 COMMISSIONER FIRESTONE: What kind of
25 research would you expect these departments to undertake
26 if this recommendation was to be implemented?

27 MR. LANGER: Well, the Department
28 of Veterans Affairs, most of these departments carry
29 out both intermural and extramural research activities.

30 COMMISSIONER FIRESTONE: Do I under-
stand they are not doing any research?

MR. LANGER: In vision we are speaking
of, sir. They are engaged in research activities in the



Langer

9646

1
2
3
4 health field, but very little with regard to vision.
5 Now, vision as opposed to medical treatment, I couldn't
6 speak with respect to that, but I do believe there are
7 research programs with respect to evaluating medical
8 eye procedures, but with respect to vision the intermural
9 programs could be modified by the inclusion of
10 optometrists to include research in the field. In
11 addition there are a number of clinical surveys provided
12 through these departments which could be expanded to
13 include provision for a research orientation. This is
14 more a matter of orientation than requiring a large number
15 of people to be involved or even necessarily large
16 expenditures of money.

17
18 COMMISSIONER FIRESTONE: If, for
19 example, the Department of Veterans Affairs were to come
20 to your College and ask you specifically what kind of
21 research you had in mind do you have a proposal to make?

22
23 MR. LANGER: I think Dr. Bobier could
24 likely answer that question better.

25
26 DR. BOBIER: Well, the nature of the
27 research program that they may ask could vary considerably.
28 It may be in the nature of a pure research in vision or
29 one that would be applicable to their work in providing
30 for the people that it is their responsibility to provide
for. Under the scope of optometrical research I might
indicate what this is by listing, as it were, a number
of papers that were given by optometrical researchers
at the Academy meeting, recent Academy meeting. I would
list them as these: The relationship between visual
acuity contrast sensitivity, stray light and age;



1
2
3
4 examining the mentally retarded child; the relationship
5 between refraction to age six to that at age 12 --
6 obviously this wouldn't be of interest to the Department
7 of Veteran Affairs, but it could very well be of interest
8 to the Department of Health and Welfare; the comparison
9 of corneal and scleral tonometry, the relationship
10 between accommodation and conversion of vision; the
11 vision of night driving; the effect and near work
12 illumination level in monkey refraction; night and space
13 myopia; vision as related to reading problems; the
14 lighting for effective seeing; the new substances for
15 contact lenses; and visual aspects of space flight --
16 this is a study by an optometrist in the American army.
17 This, I realize, is not a direct answer to the question
18 of the problems in research for the Department of
19 Veterans Affairs, but it does, I hope, give you an idea
20 of the nature and scope of the research that optometrists
21 are doing and the nature and scope of research that we
22 wish to get established in Canada.

23
24 COMMISSIONER FIRESTONE: Why could
25 research not be carried out at the College? Why would
26 you like to see government departments do research in
27 this field?

28 DR. BOBIER: - We would want such research
29 to be carried out at the College, but at the same
30 time there would obviously be studies that these various
groups would have would be pertinent to vision as they
are pertinent to other problems in medicine.

31 COMMISSIONER FIRESTONE: Do these
32 departments employ optometrists at the present time?



Langer

9648

1
2
3
4 MR. LANGER: To our knowledge the
5 answer is yes. There are some optometrists in the
6 Department of Veterans Affairs. I think there is or
7 was optometrists in the Department of Northern Affairs
8 and Natural Resource and in National Defence.

9 COMMISSIONER FIRESTONE: Thank you.
10 May I turn now to paragraph C on page V paragraph X where
11 you suggest that federal, provincial governments provide
12 grants to the College of Optometry of Ontario to support
13 under-graduate education. You are speaking in the body
14 of the text of a deficit which you estimate for 1965
15 of \$175,000.00. Is the implication of this recommenda-
16 tion that you would like to see the grants be given to
17 the full extent of \$175,000.00 budget deficit expected?

18 MR. LANGER: No, I don't think that
19 that is what we mean. I think what we are indicating
20 here is if we go to the federal level, the federal level
21 through an agency makes available to institutions of
22 higher learning the grants per annum based on population
23 of that particular province. I believe at the moment
24 it is \$2.00 per head in each province. What we are
25 suggesting here is that between the federal and provincial
26 governments those grants are being made available to
27 institutions of higher learning should be made equally
28 available to the College.

29 COMMISSIONER FIRESTONE: As far as the
30 Federal Government is concerned, sir, what would be your
31 recommendation on federal grants to be given to the
32 College of Optometry of Ontario in its initial days.

33 THE CHAIRMAN: How many students have
34 you at the College?



Langer

9649

1
2
3
4 MR. LANGER: At the moment the under-
graduate body is 65 as indicated in the submission.

5 THE CHAIRMAN: Do I understand you
6 correctly, that you want the same available grants as
7 the university students get, the same annual grants?

8 MR. LANGER: That is correct, sir.

9 COMMISSIONER FIRESTONE: On the basis
10 of your student body?

11 MR. LANGER: That is correct, sir.

12 COMMISSIONER FIRESTONE: That is fine.
13 Thank you very much.

14 THE CHAIRMAN: Dr. Baltzan?

15 COMMISSIONER BALTZAN: Dean Fisher,
16 I would like to address this question to you: The
17 university affiliated schools of optometry or faculties
18 of optometry in the universities, do they maintain
19 separate departments of zoology, anatomy, physiology,
20 neurology et cetera, or are they integrated with the
existing departments of the university?

21 DEAN FISHER: They are integrated with
22 existing departments of the university. In some cases
23 these subjects, some of them at any rate are required
24 as pre-requisites for enrolling in the optometry
department of the faculty.

25 COMMISSIONER BALTZAN: Thank you. Under
26 your existing teaching system, besides these things I
27 have enumerated here, along the line of basic training,
28 do your students also get some acquaintance with
Systemic disease?

29 DEAN FISHER: Insofar as Systemic
30 diseases affect the visual system, yes. The course in



Fisher

9650

1
2
3 recognition of disease which is given includes reference
4 to such conditions as diabetes, for example, which has
5 an effect on the eye in order that the student would
6 be able to detect these conditions and refer them to
7 the proper authorities.

8 COMMISSIONER BALTZAN: In other words,
9 I understand from you, sir, that they are informed
10 about retinopathy.

11 DEAN FISHER: Correct.

12 COMMISSIONER BALTZAN: They are trained
13 in the recognition of systemic diseases.

14 DEAN FISHER: That is correct.

15 COMMISSIONER BALTZAN: As may be seen
16 in conditions of the eye?

17 DEAN FISHER: Correct.

18 COMMISSIONER BALTZAN: One more thing,
19 sir, I see on page 18, 58, you say over half of the
20 student's time is spent at the clinic. Is the clinic
21 at your school? Is that the clinic you mean?

22 DEAN FISHER: Yes sir.

23 COMMISSIONER BALTZAN: Do they attend
24 any other types of public clinics or those associated
25 with hospitals?

26 DEAN FISHER: No.

27 COMMISSIONER BALTZAN: I won't ask
28 why. Lastly, and I hope you will think it is quite
29 in order, but I want to make sure, are all practising
30 optometrists in Canada graduates of recognized schools
of optometry?

DEAN FISHER: I can answer it this way.



Fisher

9651

Most of the Optometry Acts came into enforcement in 1921 or thereafter. There are a few provinces where the legislation was in effect in 1907 and 1908. Naturally, in all such legislation there is inserted what is termed a "grandfather" clause, whereby existing practitioners are permitted to continue. This would still be the case. If a person were in practice in 1920 in Ontario, he might be around age 25 and today he would be 67 and he might still be practising, but all new graduates, all new practitioners are graduates of recognized colleges.

COMMISSIONER BALTZAN: That is the only way they may now be licensed?

DEAN FISHER: That is correct.

COMMISSIONER BALTZAN: Thank you very much.

THE CHAIRMAN: Thank you very much gentlemen. As you will appreciate there are two other submissions in connection with your profession. They are all related. We would like you to remain if you can to follow through this discussion.

MR. LANGER: On behalf of our colleagues we thank you and we hope we have been of some aid to you.

-

-



E/ss

9652

THE SECRETARY: Mr. Chairman, we will now have the Canadian Association of Optometrists and they have filed a French version of that brief with me. The English version will be known as Exhibit No. 262; the French as No. 262 A.

---EXHIBIT NO. 262: English version of submission by the Canadian Association of Optometrists.

S U B M I S S I O N O F
THE CANADIAN ASSOCIATION OF OPTOMETRISTS

APPEARANCES:

EMANUEL M. FINKLEMAN, Winnipeg,
President, Canadian Association of Optometrists

JOHN J. MULROONEY, Halifax,
Treasurer of the C.A.O.

JACQUES VINSON, Hull,
Quebec delegate to the C.A.O.

HAROLD C. ARNOLD, Saskatoon,
Past President of the C.A.O. and Chairman
of the C.A.O. Social and Health Care Trends
Committee.

EDWARD B. HIGGINS, Toronto,
Managing Director, Canadian Association of Optometrists.

---EXHIBIT NO. 262A: French version of the submission of the Canadian Association of Optometrists.

THE SECRETARY: Mr. Higgins will introduce his group and he proposes to read the conclusions in the English language at II in the English copy and Mr. Vinson will read the recommendations in V of the French copy.



10

They have been a French version of that letter with me.
The original version will be sent to the British in 1951; the
French as No. 10. A.

---The French version of
the original version of the French
version of the French
version of the French

French version of the French
version of the French

French version of the French
version of the French

French version of the French
version of the French

French version of the French
version of the French

French version of the French
version of the French

French version of the French
version of the French

French version of the French
version of the French

French version of the French
version of the French

French version of the French
version of the French

French version of the French
version of the French

French version of the French
version of the French



Higgins 9653

MR. HIGGINS: Mr. Justice Hall,
Mademoiselle Girard, and Members of the Royal Commission
on Health Services. First of all, may I introduce myself.
My name is Edward B. Higgins. I am the Managing Director
of the Canadian Association of Optometrists. On behalf
of our Council, our members, I would like to extend to
you, Mr. Chairman, the Members of your Board our very
real thanks for the privilege extended to us today of
making this presentation.

I would like to introduce the members
of our Committee here this morning. On my right is
Emanuel M. Finkleman of Winnipeg, President of the
Canadian Association of Optometrists. On my far left is
Jacques Vinson of Hull, Quebec, who is the Quebec Delegate
to the Canadian Association of Optometrists. On his
right is John J. Mulrooney, Halifax, who is Treasurer
of the Canadian Association of Optometrists and on my
immediate left is Harold C. Arnold of Saskatoon who is
Past President of the Canadian Association, and Chairman
of our Hospital and Health Care Trends Committee.

Our Chairman, Harold Arnold, will
make the presentation to you.

MR. ARNOLD: I propose to read the
summary of conclusions and recommendations. I propose to
read the conclusions portion of it and then I will ask
Jacques Vinson, our Quebec Delegate to read the recommenda-
tions in French, if this meets with your approval.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS



1911

Mr. J. H. ...

... and ... of the ...
 on
 by
 of the
 on our

... ..
 of our

 Canadian Association of

 to the Canadian Association of
 right is John C.
 of the Canadian Association of

... ..

...



Arnold 9654

1. Comprehensive health care includes all phases of eye care. Total eye care is usually divided into three categories:
 - (1) Vision care, which includes the whole of optometrical care, and that portion of medical care which does not involve the treatment of pathological conditions or the performance of surgery.
 - (2) Optometrical care which involves only the employment of an optometrist in his professional capacity.
 - (3) Medical eye care which involves only the services of a physician in treating pathology or performing surgery.
2. Total eye care services are rendered by the optometrist, the medical refractionist and the optician. There were 1,430 optometrists and 590 medical refractionists in Canada as of December 30, 1961. The 590 medical refractionists consisted of 290 certified ophthalmologists, 161 eye, ear, nose and throat practitioners and approximately 135 general practitioners engaged in eye work. (See Appendix, Exhibits Nos. 1-13)
3. Medical practitioners tend to congregate in larger centers where better hospital facilities are available. Optometrists have both a larger number of practitioners and a wider distribution. Many areas lack local eye care services. Distribution is not ideal and 280 more practitioners are needed to fulfil present needs.



Arnold 9655

4. The ratio of practitioners to population is:

Optometrists 1: to 12,625

Certified
Ophthalmologists 1: to 59,778

Eye, Ear, Nose and
Throat 1: to 110,646

The ratio of all practitioners is, 1: to every
8,818

The ideal ratio is thought to be, 1: to every
7,500

5. Optometrists comprise 70% of the practitioners
and render approximately 65% of vision services.

6. The bulk of eye care is rendered in private
offices. Very little is done through Government
welfare plans excepting in Western Canada where
approximately 30,000 people a year receive care
on an indigent basis heavily subsidized by the
professions. Screening surveys are conducted in
schools and factories. School surveys are not
frequent or thorough enough. Pre-school screen-
ing is almost totally neglected. A "refraction
benefit" which provides only an examination is
available in some industrial prepaid health
plans. Utilization is limited because services
are available from certified ophthalmologists
only. Most plans do not include complete vision
care.

7. Optometric vision care provides a unified
service including recognition of pathological
conditions as manifested in the eye.
Medical vision care is usually divided between



Arnold 9656

the practitioner and the dispensing optician.

Medical eye care includes the diagnosis and treatment of pathological conditions.

8. Existing vision care services can be improved in the following manner:

(1) Secure more practitioners. Total requirements for the next two decades are,

1960 - 56

1965 - 94

1970 - 113

1975 - 125

1980 - 140 (see Appendix Exhibits no. 12 and No. 14)

(2) Give grants in aid to educational institutions.

(3) Provide screening facilities for school and pre-school children.

(4) Establish bursaries and scholarships.

(5) Increase programs of vision care and make greater use of professional personnel.

(6) Maintain and improve post graduate training.

(7) Establish a National vision agency.

(8) Establish rural health clinics.

9. Colleges of Optometry do not receive adequate financial assistance. With minor exceptions they are financed solely by tuition fees and the optometrists themselves.

10. Optometrists served approximately 1,487,200 patients in 1960 (see Appendix, Exhibit No. 4). The total cost of vision care in Canada in 1961 is estimated to have been \$52,295,000. Utilization in Canada is approximately 13%. Utilization



The position of the physician, however, is not
the same in all cases. The physician is
not a mere observer.

Existing conditions may be improved
by the following means:

1. The most important factor is the
mental state of the patient.

- 2. The next factor is the
physical condition of the
patient.

3. The third factor is the
social environment of the patient.

4. The fourth factor is the
economic condition of the patient.

5. The fifth factor is the
educational level of the patient.

6. The sixth factor is the
moral condition of the patient.

7. The seventh factor is the
religious condition of the patient.

8. The eighth factor is the
political condition of the patient.

9. The ninth factor is the
cultural condition of the patient.

10. The tenth factor is the
intellectual condition of the patient.

11. The eleventh factor is the
emotional condition of the patient.

12. The twelfth factor is the
volitional condition of the patient.

13. The thirteenth factor is the
moral condition of the patient.

14. The fourteenth factor is the
intellectual condition of the patient.

15. The fifteenth factor is the
emotional condition of the patient.

16. The sixteenth factor is the
volitional condition of the patient.



Arnold 9657

in England and Wales under the National Health Services Act in 1958 ~~was~~ 11.1%.

11. Research in the field of vision is relatively neglected. It should be encouraged and stimulated by Federal and Provincial grants.

12. It is both feasible and desirable to establish priorities in developing health and vision care services.

Priorities occur in this order:

(1) Secure more personnel and enlarge training facilities

(2) Provide increased services for indigents and children

(3) Enlarge public health facilities to include vision care

(4) Promote research

13. In England and Wales, under the National Health Services Plan, both optometrists and ophthalmologists render vision services. There were 6,392 optometrists who performed approximately 90% of the refractions in 1958. It appears that an increasing number of persons are obtaining services outside of the plan. Utilization and costs were curtailed by the imposition of a deterrent fee paid by the patient.

14. There is a need for a National Health Services Planning Commission of which a committee on vision care should be an integral part. Optometry and ophthalmology should be adequately represented on such a committee.



in England and Wales under the National Health

Service and in the United States

attention in the field of vision is relatively

neglected. It would be encouraged and stimulated

by Federal and State officials

It is hoped that the following will be of some

importance in developing health and vision care

activities occur in this country

(1) Secure more personnel and training

(2) Provide increased services for

children and children

(3) Enlarge public health facilities

to include vision care

In England and Wales, under the National Health

Service plan, both ophthalmists and opticians

log and render vision services. There were

2,307 ophthalmists who performed approximately

30% of the refractions in 1953. It was

that an increasing number of persons are

obtaining services outside of the public health

system and cost were controlled by the insurance

plan of a government body by the patient.

There is a need for a National Health Service

vision care should be an integral part of the

and public health system as a whole

that of a country



Arnold 9658

15. Optometry is prepared to consider any program which is designed to render better services to the public through the medium of satisfactory utilization of professional personnel.

MR. VINSON: M. Le président, mlle Girard messieurs les commissaires.

RECOMMENDATIONS

L'Association Canadienne des Optométristes est surtout intéressée aux soins visuels. Cependant ces soins sont intimement liés à tout le domaine des services de santé et les recommandations qui suivent tiennent compte de ce contexte:

(1) Qu'un plan d'ensemble des services de santé pour tout le pays soit mis en vigueur pour fournir un service de Santé complet aux catégories énoncées aux paragraphe nombre 89 et nombre 90 de ce mémoire.

(2) Qu'un tel plan soit financé conjointement par des octrois des gouvernements fédéral et provinciaux, ainsi que par des primes personnelles et des frais d'utilisation s'il y a lieu.

(3) Qu'une vigoureuse campagne de recrutement soit entreprise pour obtenir plus d'étudiants en optométrie. Des bourses d'études et des octrois sont suggérés comme moyens d'action.

(4) Que les collèges d'optométrie et les autres institutions d'enseignement soient aidés financièrement afin d'améliorer et



1 d'augmenter leur rendement.

- 2 (5) Que les programmes pour la santé publique s'étendent
3 au dépistage des défauts visuels chez les enfants
4 au niveau pré-scolaire et scolaire et à une plus
5 grande utilisation des services des optométristes et
6 des ophtalmologistes.
- 7 (6) Que les recherches dans le domaine de la vision
8 soient encouragées et aidées par des octrois directs.
- 9 (7) Qu'un bureau national de vision, ou une agence, soit
10 mis sur pied, comme sous-comité d'une Commission de
11 Planification des Services de Santé Nationale.
- 12 (8) Que des cliniques rurales de santé soient établies
13 dans les localités où manque un service adéquat.

14 THE CHAIRMAN: Merci beaucoup, monsieur Vinson
15 and Mr. Arnold. Now, you were listening in on the
16 previous submission and the discussion that took place.
17 Having heard what was said and so forth, have you any
18 observations to make at this moment in connection with
19 what has already been discussed this morning?

20 MR. ARNOLD: I would think the aspect of
21 this hearing that you explored there would be academic.
22 After that we should maybe enter into a discussion more
23 along the lines that are proposed in our recommendation.
24 I think the recommendations do tie in, to some extent.

25 THE CHAIRMAN: There is an overlapping and
26 to that extent we would not be going over the same ground
27 again.

28 MR. ARNOLD: As far as I know, there is no
29 difference of opinion except in one statement that I
30 believe the C.A.O. feels there is a shortage, whereas,
as stated by Mr. Baker ---

THE CHAIRMAN: They think it is only in

1. The first question is whether the evidence is sufficient to establish the fact of the crime.

2. The second question is whether the evidence is sufficient to establish the fact of the crime.

3. The third question is whether the evidence is sufficient to establish the fact of the crime.

4. The fourth question is whether the evidence is sufficient to establish the fact of the crime.

5. The fifth question is whether the evidence is sufficient to establish the fact of the crime.

6. The sixth question is whether the evidence is sufficient to establish the fact of the crime.

7. The seventh question is whether the evidence is sufficient to establish the fact of the crime.

8. The eighth question is whether the evidence is sufficient to establish the fact of the crime.

9. The ninth question is whether the evidence is sufficient to establish the fact of the crime.

10. The tenth question is whether the evidence is sufficient to establish the fact of the crime.

11. The eleventh question is whether the evidence is sufficient to establish the fact of the crime.

12. The twelfth question is whether the evidence is sufficient to establish the fact of the crime.

13. The thirteenth question is whether the evidence is sufficient to establish the fact of the crime.

14. The fourteenth question is whether the evidence is sufficient to establish the fact of the crime.

15. The fifteenth question is whether the evidence is sufficient to establish the fact of the crime.

16. The sixteenth question is whether the evidence is sufficient to establish the fact of the crime.

17. The seventeenth question is whether the evidence is sufficient to establish the fact of the crime.

18. The eighteenth question is whether the evidence is sufficient to establish the fact of the crime.

19. The nineteenth question is whether the evidence is sufficient to establish the fact of the crime.

20. The twentieth question is whether the evidence is sufficient to establish the fact of the crime.

21. The twenty-first question is whether the evidence is sufficient to establish the fact of the crime.

22. The twenty-second question is whether the evidence is sufficient to establish the fact of the crime.

23. The twenty-third question is whether the evidence is sufficient to establish the fact of the crime.

24. The twenty-fourth question is whether the evidence is sufficient to establish the fact of the crime.

25. The twenty-fifth question is whether the evidence is sufficient to establish the fact of the crime.

26. The twenty-sixth question is whether the evidence is sufficient to establish the fact of the crime.

27. The twenty-seventh question is whether the evidence is sufficient to establish the fact of the crime.

28. The twenty-eighth question is whether the evidence is sufficient to establish the fact of the crime.

29. The twenty-ninth question is whether the evidence is sufficient to establish the fact of the crime.

30. The thirtieth question is whether the evidence is sufficient to establish the fact of the crime.



Arnold 9660

certain restricted areas.

MR. ARNOLD: So there is a disagreement.

THE CHAIRMAN: This matter of shortage, I suppose it may be said that the practice of optometry lends itself to an itinerant practice perhaps more than any other health service, does it not? Is that not the fact that the optometrists do go from place to place? They are able to carry portable equipment which does a reasonably satisfactory job?

MR. ARNOLD: This can be done, but it isn't the general rule by any means. I don't know what the percentage would be, but I suspect the percentage would be 15% or less.

THE CHAIRMAN: I am just thinking of the way some of the people in Saskatchewan do it.

MR. ARNOLD: That is right, including me.

MR. MULROONEY: It's more prevalent in Western Canada.

THE CHAIRMAN: Is this something that is more prevalent in Western Canada than any other part of Canada?

MR. ARNOLD : It's more prevalent wherever there are larger rural areas and in Newfoundland where it is done by both groups.

THE CHAIRMAN: That has a decided bearing on this question of manpower and shortages?

MR. ARNOLD: That is right.

THE CHAIRMAN: Coming to a much broader question, and perhaps it may be over-simplified in the way I may put it to you, in your recommendation, the first



Arnold 9661

1
2
3
4 recommendation read by Mr. Vinson that a Nation-wide
5 comprehensive health care plan be encouraged, I assume
6 it is implicit in that that optometry be brought within
7 such a plan. Is that what you mean?

8
9
10
11
12
13
14
15
16 MR. ARNOLD: Yes.
17
18
19
20
21
22
23
24
25
26
27
28
29
30

Page No. 9666 follows.



THE UNIVERSITY OF MICHIGAN
LIBRARY

RECEIVED [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible] [illegible]

[illegible]

[illegible]

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100



L/hm

1
2
3
4 THE CHAIRMAN: Just considering the
5 philosophy behind the idea of a comprehensive medical
6 care plan, we hear in many places that the reason, the
7 need for such a plan is that while some people are able
8 to pay for their services that almost everyone, except
9 very few, are vitally affected by prolonged illness,
10 prolonged hospitalization, these things that come
11 within the catastrophic category of health services.
12 Now, in that context, where does optometry come in,
13 or do you see it as having any place in this catastrophic
14 picture of health services which society says must be
15 protected against?

16 MR. ARNOLD: My answer to that would
17 be it is not of a catastrophic nature. I think it would
18 be foolish to argue on that basis. But we feel it is
19 very much of an essential nature, we feel that this
20 service we provide is probably for the most common
21 ailment to humanity, and on this basis alone is one of
22 the most essential.

23 COMMISSIONER McCUTCHEON: Dr. Strachan
24 would probably argue that point with you.

25 THE CHAIRMAN: You see, when we come
26 into the discussion of prepayment of a plan we naturally
27 become involved in the concept of prepayment. What
28 do you see as the situation in terms of prepayment?
29 I need an examination, I may need a new pair of glasses
30 or I may be a youngster, and so forth, and I need glasses
for the first time. Is it the kind of thing which will
lend itself to a prepayment proposition, prepayment
plan?



Arnold

9667

1
2
3
4 MR. ARNOLD: I don't see any conditions
5 which would say no to that.

6 THE CHAIRMAN: Well, if I may put it
7 this way. I may be, as I say, oversimplifying it too
8 much. But John Smith today gets the glasses that he
9 requires. Now, he may break them and have them repaired;
10 that is another story. But ordinarily he will not look
11 forward to having the procedure repeated for five, six
12 or ten years?

13 MR. ARNOLD: Statistically, it works
14 out somewhere between 34 and 36 months.

15 THE CHAIRMAN: All right, three years.
16 So having bought his glasses, why would you persuade
17 him to pay a premium for the next two years when there
18 is no expectation ---

19 MR. ARNOLD: This is one of the most
20 difficult controls you have to establish with respect
21 to this type of service. I know that some medically-
22 sponsored schemes provide a refraction benefit and they
23 provide them yearly, if necessary. I know in
24 Saskatchewan under the Department of Health that we
25 had it for two years. Then it becomes a difficult
26 problem of administration how to police this thing and
27 to see that it is maintained on a two-year basis. But
28 beyond these reservations I don't see why vision care,
29 in total, not just the provision of glasses but the whole
30 aspect, could not be integrated into a comprehensive
health care plan, no matter how it is sponsored.

COMMISSIONER McCUTCHEON: Is the
optometrist included in the medical care plan in



Arnold

9668

1
2
3
4 Saskatchewan?

5 MR. ARNOLD: At the moment, no.

6 COMMISSIONER VAN WART: I notice on
7 page 27 you state that the total cost of vision care
8 is 52-plus million dollars, and you also go on to state
9 what it does not include. Have you any idea what the
10 overall figure would be if you included all these
11 exclusions you have made?

12 MR. ARNOLD: In other words, have we
13 any idea of the cost of surgical care, treatment of
14 disease?

15 COMMISSIONER VAN WART: The whole
16 picture. Would it be 60 million, 100 million?

17 MR. ARNOLD: I have no idea.

18 COMMISSIONER VAN WART: Outside of what
19 you are speaking of in Saskatchewan, is there any other
20 plan in which optometrists participate in a prepaid
21 scheme?

22 MR. ARNOLD: Certainly in England
23 and Wales ---

24 COMMISSIONER VAN WART: I mean in this
25 country.

26 MR. ARNOLD: Mr. Higgins can answer
27 this with respect to health plans which are sponsored
28 by unions and management.

29 DEAN FISHER: There are a number of
30 health and welfare plans sponsored jointly by management
and labour operated under joint trustees who purchase
a schedule of benefits for the members of the union
covered under the plan. There are a number of such plans



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

THE

OF

AND

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE



Fisher

9669

1
2
3 which do include refraction benefits, and the refraction
4 service can be rendered for either an optometrist or
5 an ophthalmologist. There are several plans.

6 COMMISSICNER VAN WART: Outside of
7 the unions, do you know of any other?

8 DEAN FISHER: The Secondary School
9 Teachers' Association does have a refraction benefit for
10 its members, and there is no restriction as to the
11 personnel who can render that service.

12 COMMISSIONER VAN WART: And they are
13 financially solvent, are they, these plans?

14 DEAN FISHER: Oh, yes, sir, they are
15 quite solvent.

16 COMMISSIONER McCUTCHEON: The union
17 would have something to say if they were not?

18 DEAN FISHER: I think management would
19 have more to say if they were not, sir.

20 THE CHAIRMAN: What do you say about
21 page 3, Summary of Conclusions, paragraph 8, subsection
22 7, establish a national vision agency?

23 MR. ARNOLD: I would refer you to
24 paragraphs 59 and 95 in the brief with respect to that.
25 If you will permit me to answer by reading paragraph
26 55.

27 "When discussing vision care services
28 "and the proper utilization of vision
29 "care personnel, it is essential to
30 "remember that there are three groups
"involved, namely, optometry,
"ophthalmology and opticianry. The



Arnold

9670

"public utilizes the services of all
"three and indeed, they utilize the
"services of each other. This relation-
"ship occurs in the absence of any
"formal or official organization. To
"a large extent it suffers from a lack
"of easy communication and constructive
"planning. The creation of a national
"agency or bureau composed of people
"representing all those concerned
"would provide a means of improving both
"the present situation and the long
"term planning for the provision of
"vision care services. This Association
"would welcome and recommend such an
"agency."

This is what we mean when we recommend
that such an agency be set up. And in paragraph 95
we elaborate that and say:

"Indeed this applies in varying
"degrees to the relationships between
"all health professions." -----

The lack of co-ordination and lack of relationship.

"A national agency or committee on
"vision care sponsored by the
"appropriate Department of the Federal
"Government was suggested in paragraph
"No. 55 as a sub-committee under an
"overall Health Services Planning
"Commission."



Arnold

9670

1
2
3
4 COMMISSIONER FIRESTONE: If I may
5 follow this up, Mr. Chairman, this suggestion of a
6 national health services planning commission. That is
7 a new suggestion to us. As I understand it, having
8 read both paragraphs 55 and 95, you anticipate that this
9 national agency on vision care would be one of the
10 many sub-groups of this larger central organization.
11 Is it really a central organization? What do you have
12 in mind when you recommend or speak of the need for a
13 national health services planning commission? What
14 would be its function, who would be on it, how would it
15 work?

16 MR. ARNOLD: Our Association would
17 envisage it being a committee composed of members from
18 the interested federal agencies, whoever they may be,
19 definitely the Department of National Health and Welfare;
20 there would need to be on it representative of lay
21 organizations, and it seems to me that out of the
22 recommendations of your Committee you are going to make
23 recommendations to the Federal Government, and I would
24 imagine a national health services commission would be
25 the mode by which it would be done.

26 COMMISSIONER FIRESTONE: Without
27 anticipating what this Commission will or will not do,
28 we are really interested in your views of what you feel
29 would be a desirable manner in implementing your idea
30 of a planning commission. Would it include representa-
tives of the Provincial Government as well?

MR. ARNOLD: Definitely.

COMMISSIONER FIRESTONE: You speak of



Arnold

9671

1
2
3
4 co-ordination, you speak of planning. What do you mean
5 by planning and co-ordination?

6 MR. ARNOLD: Well, this is a difficult
7 question to answer and it is a very long, arduous question
8 to answer. But it would certainly mean such a Commission
9 could sit down with representatives of the various
10 groups and decide on a course of action to be taken
11 at any particular time. If this isn't done at some time
12 prior to the scheme then plans are apt to be instituted
13 which are not acceptable.

14 COMMISSIONER FIRESTONE: Well, I am
15 just trying to understand how this Commission would
16 work. If problems develop in the health field you feel
17 that this very large commission, one federal government,
18 ten provincial governments, representatives of lay
19 groups, professional groups, 40 or 50 members, you
20 anticipate a discussion and then coming forward with
21 recommendations?

22 MR. ARNOLD: Yes. This is exactly
23 the way it is being done in Saskatchewan. There is
24 a health services planning commission which was set up
25 prior to the establishment of the hospital services
26 scheme and the medical care scheme which is now in
27 issue.

28 COMMISSIONER FIRESTONE: If I then
29 understand you correctly, sir, your recommendation would
30 be that the principles that have been followed in
setting up this planning organization in Saskatchewan
might be applied to a much broader agency and this
would be the planning commission as recommended in that



...and

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..



Arnold

9672

paragraph?

MR. ARNOLD: Yes.

COMMISSIONER FIRESTONE: Thank you very much.

COMMISSIONER BALTZAN: I have just one question. Are the certification examinations in Saskatchewan under the aegis of the University of Saskatchewan?

MR. ARNOLD: Yes.

COMMISSIONER BALTZAN: And the examining body is composed of?

MR. ARNOLD: The examining body in Saskatchewan is composed of the Dean of Medicine, who is the chairman, the Professor of Ophthalmology, an examiner, two optometrists who are examiners and two optometrists who set the written papers.

COMMISSIONER BALTZAN: And your organization in Saskatchewan is quite satisfied with that arrangement?

MR. ARNOLD: You are never wholly satisfied with it. We are satisfied with it. It can be improved.

COMMISSIONER BALTZAN: You are satisfied with it?

MR. ARNOLD: Yes.

COMMISSIONER GIRARD: I just wondered if the question of this School of Optometry is the same in other provinces as it is in the Province of Quebec where I believe the optometrists in the School of Optometry can apply for training bursaries, bourses de



Arnold

9673

1
2
3 l'aide à la jeunesse?

4 MR. VINSON: Elles existent en
5 optométrie.

6 COMMISSIONER GIRARD: The students
7 cannot apply for these bursaries?

8 MR. VINSON: Yes.

9 COMMISSIONER GIRARD: And do you know
10 how much they make use of them?

11 MR. VINSON: I couldn't give you a
12 rate percentage-wise, but I would say 20%, 25%.

13 COMMISSIONER GIRARD: Would be availing
14 themselves of these bursaries?

15 MR. VINSON: Or loans.

16 COMMISSIONER GIRARD: They have to
17 repay 40%?

18 MR. VINSON: Yes.

19 COMMISSIONER GIRARD: Coming to a
20 question asked by Dr. Baltzan a little earlier, I got
21 the impression that optometrists are not found very
22 much in hospital clinics. Now, I know of hospitals in
23 the Province of Quebec where there are optometrists in
24 hospital clinics along with ophthalmologists. Is this
25 unique, or did I get a wrong impression?

26 MR. ARNOLD: They are not to my
27 knowledge anywhere in Canada found in hospital clinics.

28 COMMISSIONER GIRARD: Not anywhere,
29 do you say, in out-patients departments?

30 MR. ARNOLD: You are talking of out-
patient departments?

COMMISSIONER GIRARD: Yes.



Arnold

9674

MR. ARNOLD: With the exception of
one or two of the Department of Veterans' Affairs
hospitals, the answer is no.



Arnold

9676

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
/dpw
COMMISSIONER McCUTCHEON: Except in
Quebec?

COMMISSIONER GIRARD: Except in Quebec,
because I know of some and that is why I was surprised
to hear this. I was wondering whether this was unique.
I suppose I should not ask the reason for that; what is
the reason?

THE CHAIRMAN: Or is there a reason?

MR. ARNOLD: There is a reason, probably
several reasons.

THE CHAIRMAN: Many of these reasons
are historic in the historical development?

MR. ARNOLD: That is right. I would
think, in the first place, that optometry has not pressed
this issue. It is only in the last several years we
thought it would be a necessary procedure and it was a
service that could be well set up. There is no question
that it involves a misunderstanding, to some extent,
between medicine on the one hand and optometry on the
other as to the area of training and the discipline we
have and how we could arrive at an understanding and
implement a different program, I do not know whether this
could be done or not.

COMMISSIONER BALTZAN: Are you acquainted
with that same situation that Miss Girard brought before
you as it exists in the United States?

MR. ARNOLD: No, again, I could not
speak with any authority at all on the situation in the
United States.

COMMISSIONER BALTZAN: I have some



knowledge but we will delay that.

COMMISSIONER GIRARD: Thank you very much.

THE CHAIRMAN: Thank you very much, gentlemen. We will take a short recess now and proceed with the submission of the Ontario Association.

--- Short Recess

THE SECRETARY: The next submission will be from the Optometrical Association of Ontario and it will be known as Exhibit 265.

--- EXHIBIT NO. 265: Submission of the Optometrical Association of Ontario.

SUBMISSION OF THE OPTOMETRICAL ASSOCIATION
OF ONTARIO

Appearances: Dr. T.R. Bobier
Dr. R. Thomson
Dr. M.E. Woodruff
Col. J.W. Duffy
Mr. D.H. Lamont

DR. WOODRUFF: Mr. Chairman, I am a practising optometrist from Blenheim, Ontario, and Vice-President of the Optometrical Association of Ontario. I would like to introduce my group: on my right I have Tom Bobier, our Treasurer; the President of the Association, Robert Thomson; our Administrative Director, Colonel Jim Duffy and I think you have been introduced to Mr. Lamont.

I think from the prior briefs we do



Woodruff

9678

1
2
3 have a few comments before we proceed with our own.
4 We noted that there was a question as regards health
5 plans and optometrical care in Great Britain was included
6 from the onset of their plan and in both hospitals and
7 private practice. This is still the case. They had
8 anticipated, I understand, in their initial planning,
9 to eventually eliminate private practice and have all
10 the services in the hospital but this has proved to
11 work well enough in the system that was initially set
12 up that they have continued. I do not know that they
13 presently plan to discontinue this method.

14 COMMISSIONER BALTZAN: Did you say they
15 originally included all this?

16 DR. WOODRUFF: They originally included
17 it and they have continued with it as they originally
18 evolved it. Originally it was intended to eliminate
19 the private practice and have the service move into the
20 hospital exclusively but that has not occurred. There
21 are still men in the hospitals and certain types of
22 services, special services, are referred there to the
23 optometrist in the hospital but the general practitioner
24 of optometry is still in private practice.

25 COMMISSIONER BALTZAN: It is not
26 covered under the scheme?

27 DR. WOODRUFF: Yes, it is.

28 THE CHAIRMAN: Optometry itself, not
29 the provision of glasses.

30 DR. WOODRUFF: There is a deterrent fee
but if you are within an indigent group you are capable
of receiving service at no charge to yourself under the



Woodruff

9679

1
2
3 British health scheme. I just thought that was not made
4 quite clear by the other groups. Also, in regard to the
5 employment of optometrists in hospitals in Canada, there
6 are a few instances where optometrists are employed.
7 There have been, I am sorry to say, instances where
8 optometrists have asked for admission to out-patient
9 clinics and have been refused. I know of one in Toronto,
10 Mount Sinai. I am at present engaged to do refractions
11 for, and this will entail in-hospital work and it is
12 personal, the Ontario Hospital School which is an insti-
13 tution for the care of retarded children at Cedar
14 Springs, Ontario. The Medical Superintendent of this
15 hospital asked me personally to perform this service
16 but my entry there has been vigorously fought by a local
17 ophthalmologist. However, I am still performing this
18 service in this particular instance.

19 Now, there are others throughout
20 Ontario who are doing this service for Ontario hospitals.

21 COMMISSIONER McCUTCHEON: You mean
22 government hospitals?

23 DR. WOODRUFF: By that, I mean government
24 hospitals where the people are mentally retarded or
25 hospitals for the insane.
26
27
28
29
30



... I just thought that was not a
quite clear by the other groups. Also, in regard to the
employment of optometrists in hospitals in Canada, there
are a few instances where optometrists are employed,
but have been, I am sorry to say, treated as who
optometrists have asked for admission to out-
patient and have been refused. I know of one in Toronto
about which, I am at present engaged to be reviewed and
and, and this will entail in-hospital work and it is
... the Ontario Hospital School which is an insti-
tution for the care of retarded children at Cedar
Rapids, Ontario. The Medical Superintendent of this
hospital asked me personally to perform this service
but to enter there has been vigorously fought by a local
ophthalmologist. However, I am still performing this
service in this particular instance.
Now, there are others throughout
Ontario who are doing this service for various hospitals.
COMMISSIONER MONTGOMERY: You mean
government hospitals?
MR. WOODHUTT: By that, I mean government
hospitals where the people are mentally retarded or
hospital for the insane.



Woodruff

9680

COMMISSIONER McCUTCHEON: Where the medical profession has not got quite as much influence as they have in some of the other hospitals.

DR. WOODRUFF: No, possibly not. I don't mean this as an aspersion upon the medical profession because the people I am working for are medical and they are most gracious and our relationship is an exemplary one.

COMMISSIONER McCUTCHEON: Granted. Do you recognize any good reason why your approach to Mount Sinai Hospital wasn't accepted?

DR. WOODRUFF: None. The men who approached were well-qualified to perform the services for which they expected to be employed.

COMMISSIONER BALTZAN: Is that the only hospital?

DR. WOODRUFF: That is the only hospital to my knowledge.

COMMISSIONER BALTZAN: That applications were made to?

COMMISSIONER McCUTCHEON: You referred to the British Health Service - I don't want to interrupt.

THE CHAIRMAN: Go ahead. I think that is the idea, discussion arising out of former ones. It is what we contemplated. It is very much in order.

COMMISSIONER McCUTCHEON: There was a statement made, and I didn't comment on it at the time, to the effect that there was an increasing number of people who were seeking optometrical services outside the plan, outside the health plan.



COMMISSIONER: Yes, sir.

Medical attention was not given to him, and they have in some of the other hospitals.

MR. WOODRUFF: No, possibly not.

... ..

... ..

COMMISSIONER: Yes, sir.

Do you recognize any good reason why your appeal to

MR. WOODRUFF: None. The men who

approached were well-qualified to perform the service for which they expected to be employed.

COMMISSIONER BARTMAN: Is that the only

hospital?

MR. WOODRUFF: That is the only hospital

to my knowledge.

COMMISSIONER BARTMAN: That is all.

... ..

... ..

to the National Health Service - I don't want to inform

THE CHAIRMAN: Go ahead. I think that

the good, discussion arising out of former ones.

It is what we are interested in. It is very much in order.

COMMISSIONER WOODRUFF: There was a

statement made, and I didn't comment on it at the time,

to the effect that there was an increasing number of

people who were receiving pathological services outside

the plan, outside the health plan.



Woodruff

9681

DR. WOODRUFF: This is a matter which I think is one which hasn't been touched upon at all, and there is a reason why this occurred. The reason is that as people have recognized the need for eye care there is the question of vanity and frame selection amongst wearing lenses of a certain percentage of the population. These people seek care outside of the plan in order to satisfy the style feature of eye care. Style, in that sense, has no place within the National Health Plan because they are paying for a person's vanity in that a person who will use care provided it satisfies his vanity and avoids it unless it does. This, in my mind, justifies to some extent some of the things that occur.

COMMISSIONER BALTZAN: You might say it's psychosomatic.

DR. WOODRUFF: Psychosomatic.

COMMISSIONER GIRARD: I cannot listen to the words vanity and style without coming into this discussion. Would this mean that under the health care in England that every woman that needed glasses and was eligible to get them from the Government would have to have the same frame that would identify them as having got their glasses from the Government?

DR. WOODRUFF: I think there is a minimum standard of material supplied.

COMMISSIONER GIRARD: Then I understand it. I don't think it is fair. I think they should have, at least, three or four colours, if they don't have different styles.



Woodruff

9682

DR. WOODRUFF: I think that is done at the present time. No one goes without the care they need because they couldn't afford to pay.

COMMISSIONER GIRARD: Style is as important as care to a woman.

DR. WOODRUFF: I would agree it is a very important part of the practice in that aspect. Are there any others in my group who would wish to comment on anything that has gone on before I proceed?

In beginning to read the summary and conclusions I have a separate statement not in our brief.

It is the opinion of optometrists in Ontario that serious inadequacies exist under the present conditions in the field of vision care services. Some of these inadequacies are the lack of provision for the low-income and indigent groups; the lack of provision for the chronically ill, mother's allowance recipients and the school and pre-school child of any financial structure.

The present prepaid insurance scheme provides only diagnostic vision care and excludes the coverage of the chronically ill, the financially unable and the over-aged. This also excludes optometrist services, deprives the optometric patient of their utilization. To eliminate these inadequacies we believe there should be a government-financed scheme wherein the Government should provide, co-operate to provide and administer such care.



... I think that is ...

... the ... time, ... with ...

... because they could ...

... is ...

... as ...

... is ...

... very ...

... group who ...

... on ...

... beginning to ...

... I have a separate statement ...

... it is the ...

... that ...

... in the ...

... of these ...

... low-income and ...

... the ...

... the ...

... only ...

... of the ...

... This ...

... the ...

... to ...

... is a ...

... should ...

... and ...



Woodruff

9683

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

The ultimate aim of any future health care program for the people of Canada is to improve the health standard of all Canadians by making health care services readily available to them.

It follows therefore that vision care services, since they fall within the field of public health, should be included in any such programs.

The Optometrical Association of Ontario concludes as follows:

CONCLUSIONS

Optometrists fill a need which cannot be met except by the use of their services -- a need which increases daily as population and public awareness of the service grow. In Ontario, optometrists comprise approximately 75 percent of vision care practitioners and render from 65 to 75 percent of all vision care services.

The distribution of optometrists in Ontario provides equally good service throughout the rural and urban areas. In many rural centers, optometrists are the only practitioners available to provide the service.

We have provided you in the Appendix with a map showing the distribution of both optometrists and ophthalmologists in the Province of Ontario. There are only two counties in Ontario, one of those that quickly comes to mind is the county that comprises, a major portion of it is comprised of a park to the north of us where there is not a great population. The



The ultimate aim of any future health
care program for the people of Canada is to improve the
health of all Canadians by making health care
services readily available to them.
It follows therefore that vision care
services, since they fall within the field of public
health, should be included in any such program.
The Ophthalmological Association of Ontario
concludes as follows:

Ophthalmologists fill a need which cannot
be met except by the use of their services as a part
of the service group. In Ontario, ophthalmologists, together
with increasing rapidly as population and public awareness
of the service group. In Ontario, ophthalmologists, together
approximately 15 percent of vision care practitioners
and represent from 65 to 75 percent of all vision care
services.

The distribution of ophthalmologists in
Ontario provides equally good service throughout the
province and urban areas. In rural areas, however, service
is not available and the only practitioners available to provide
the service.

We have provided you with the following
with a view to the distribution of health care services
and ophthalmologists in the Province of Ontario. It is
not only two ophthalmologists in Ontario, one of them in
rural areas to which is the country that ophthalmologists,
a major portion of it is composed of a rural population.
In fact, of the whole there is not a great population.



Woodruff

9684

other is also a far north county so that we do cover most of the province adequately.

Optometrists are trained to detect pathology in the eye and are therefore a valuable aid in the early discovery of diseases of the eye or diseases which may manifest themselves in the eye.

Appendix A of this summary details the activities of a typical optometrists and emphasizes the necessity and extreme value of optometric services.

Optometric vision care services are provided almost entirely through the medium of private practice and are not widely available through government or welfare sources. Where welfare agencies pay for the provision of such services, optometrists accepting a responsibility toward the public co-operate by providing their services at minimal cost -- or sometimes at no cost -- to either the agency or the patient. There is a lack of uniformity in the provision of vision care services from welfare sources. This sometimes deprives the needy of care and at other times gives care to some who can rightly afford to pay for it.

Optometrists are not utilized to the extent which the public need requires. This is not due to any lack of desire on the part of the profession of optometry which is willing to participate in all avenues of service in the vision care field.

I would just speak aside from this for a moment, gentlemen. I think this is due to the lack of provision within the existing program rather than deliberate exclusion. Optometry is a profession which



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

It is also a fact that the country is not yet ready to

meet the needs of the people.

There is a need for more health services.

It is also a fact that the country is not yet ready to

meet the needs of the people.

There is a need for more health services.

It is also a fact that the country is not yet ready to

meet the needs of the people.

There is a need for more health services.

It is also a fact that the country is not yet ready to

meet the needs of the people.

There is a need for more health services.

It is also a fact that the country is not yet ready to

meet the needs of the people.

There is a need for more health services.

It is also a fact that the country is not yet ready to

meet the needs of the people.

There is a need for more health services.

It is also a fact that the country is not yet ready to

meet the needs of the people.

There is a need for more health services.

It is also a fact that the country is not yet ready to

meet the needs of the people.

There is a need for more health services.

It is also a fact that the country is not yet ready to

meet the needs of the people.

There is a need for more health services.

It is also a fact that the country is not yet ready to



Woodruff

9685

has a recent history of growth and increasing authority and increasing education and a good many of the agencies that are in existence are of long history and precede our recognition as a profession through legislation and thus it wasn't by legislative exclusion that we are not there. It is just due to our emergence as a profession.

A total of 2,068,500 people in Ontario are receiving care for vision anomalies. Of these approximately 1,500,000 receive their attention from optometrists. The annual total expenditure for all vision care in the province is estimated to be \$19,653,000 and this would increase to \$29,380,000 by 1980. The present expenditure is financed largely by individual payment to the optometrist by his patients. This is the opposite of the modern trend which is to prepay expenses and have the practitioner paid by means of insurance or other health plans.

Although 90 to 95 percent of all vision anomalies lie within the optometric field of diagnosis and treatment, research into this most important health area is not supported by any means other than optometry's own efforts.

The financing of the addition of vision care to existing health plans or in any new health plan would be most effective by prepaid plans or from public funds.

The Optometrical Association of Ontario recommends as follows:

has a capacity of growth and development and that
and that it is a condition and a good thing that
that there is a condition of long history and that
our recognition as a condition through legislation
and that it is not a condition of long history
and not there. It is not a condition of long history
and not there.

total of 1,000,000 people in the
and receiving care for vision anomalies. Of the
approximately 1,000,000 people in the vision
category. The annual total expenditure for all
vision care in the province is estimated to be \$14,000,000.
and this would increase to \$20,000,000 by 1980. The
present expenditure is financed entirely by individual
payment to the physician by his patients. This is
the opposite of the modern trend which is to have
expenses and have the expenditures paid by means of
insurance or other health plans.

Although 90 to 95 percent of all vision
anomalies lie within the operational field of diagnosis
and treatment, research into this most important health
area is not supported by any means other than doctors' fees
and effort.

The financing of the vision of vision
care to patients is a condition of long history and
which is not effective in health plans or for public
health.

The question is, how far is the vision of vision



RECOMMENDATIONS

It is recommended that:

A. Optometric clinics be established in public hospitals or optometrists appointed to the staff of hospitals to provide outpatient vision care service.

B. A number of optometrists be trained as public health optometrists and included on public health units.

C. Provision be made for vision examination of pre-school children and of school children at regular intervals by specialists in vision problems.

D. Specialists in vision be employed to direct occupational vision programs in industry and to conduct vision testing programs for motorists.

E. The implementation of any comprehensive health plan include vision care at its initial stage and include optometrists in the provision of this service.

F. Optometrists be included on any committee, national, provincial or local, which is set up to deal with health care problems.

G. Opportunity for optometric education be broadened by university affiliation of present schools; by the establishment of new schools within universities; by

Section 101

It is recommended that:

A. Ophthalmic clinics be established in public hospitals or departments, and be open to the staff or hospital, to provide treatment of the eye service.

B. A number of optometrists be retained as public health ophthalmists and included on public health units.

C. Provision be made for vision screening of pre-school children and school children at regular intervals by ophthalmists in vision programs. D. Specialists in vision be employed to direct occupational vision programs in industry and to conduct vision testing programs for motor vehicles.

E. The implementation of any comprehensive health plan include vision care at its initial stage and include ophthalmists in the provision of this service.

F. Optometrists be included on any committee, national, provincial or local, which is set up to deal with vision care problems.

G. Opportunity for ophthalmic education be provided by university affiliation of present schools; by the establishment of new schools with a unit of vision



Woodruff

9687

the establishment of post-graduate schools; by the provision of grants for optometrical schools and scholarships and bursaries for students.

H. Government aid be given for optometric research.

Finally, the members of the Optometrical Association of Ontario wish to assure the Royal Commission on Health Services they are ready to co-operate fully with all groups in any measures designed to further the health interests of the people of Canada.

THE CHAIRMAN: Thank you, Dr. Woodruff. Your paragraph on page ii that you read, immediately above the word Recommendations: The financing of the addition of vision care to existing health plans or in any new health plan would be most effective by prepaid plans or from public funds.

Would you explain just what you mean by that?

DR. WOODRUFF: We feel that the only method of really extending to all these groups that we know need care is a comprehensive health scheme. I don't think we would oppose the broadening of the existing schemes.

THE CHAIRMAN: That is the present ones?

DR. WOODRUFF: The present prepaid medical plans.

THE CHAIRMAN: Doctor-operated plans or the co-op. plans?

DR. WOODRUFF: But we certainly feel



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

The establishment of a system
conducted by the officials of the
top of the medical schools and hospitals
ships and insurance for hospitals
the Government also has given the

Finally, the members of the Commission
Association of America wish to assure the Royal Commission
on Health Services that they are ready to co-operate fully
with all groups in any measures designed to improve the
health progress of the people of Canada.

The Chairman: Thank you, Mr. Gordon.
Your remarks on page 11 that you want, particularly
to have a more comprehensive study of the
situation of the various groups to examine what is going on in
any new health plan would be most effective by the public
the Government would like to know.

Would you explain just what you mean

by that?

Mr. WOODBURY: We feel that the

work of the various groups to all these groups that we

now have is a comprehensive health survey.

What we would oppose the breaking of the existing

The Chairman: There is no need to

Dr. WOODBURY: The next step

medical progress.

The Chairman: Doctor, would you

of the current plans?

Dr. WOODBURY: I am not sure



Woodruff

9688

1
2
3 if we were excluded from this as we definitely are at
4 the present time that this wouldn't be the method of
5 serving all of this group, and therefore we feel we must,
6 if these are to be extended, be included within their
7 benefits, and if not, if this cannot be done, then we
8 feel a scheme must come through - we are not suggesting
9 how this should be done in the sense of direct taxation
10 or prepayment. We know this is not our field to do so,
11 but we feel that it should be financed by the Government
12 under any method that they choose to do so. We should
13 be included within this finance.

14 COMMISSIONER McCUTCHEON: Is the reason
15 for the suggestion you feel that is the only way
16 your services are going to be recognized?

17 DR. WOODRUFF: To some extent, yes,
18 that is a factor in our recommendation but we also feel
19 that it is a factor in extending services which are not
20 now available to large segments of the population. Some
21 of this is not due to the lack of finance of the people
22 concerned. I am thinking, therefore, particularly of
23 the pre-schoolchildren in Ontario. The pre-schoolchild
24 cannot go to school until he has a dental check-up and
25 a physical check-up. Sometimes the physical check-up
26 might include an acuity test which includes the Snellen
27 chart. This test is done at 20 feet, and he spends 80%
28 of his time in a classroom at that level.
29 If the test is inadequate here it is not discovered
30 until perhaps the end of Grade 1 or Grade 2 where he
has now encountered a failure situation. This occurs and
they are in trouble and they lose some of the important,



10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

it was excluded from this as well as the other
the present time that this would be the case
serving all of this group, and therefore we feel we
it seems to be excluded, it included with the
benefit, and it not, it this is not to be
feel a sense of some strength - as the not
now this should be done in a series of direct
on movement. Now this is not to be
but we feel that it should be done by the
under any method that they choose to do so
be included within this financial.

10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

for the association you feel it is the only way
your services are going to be provided
that is a factor in the consideration but we also
that it is a reason in existing services which are
now available to some segments of the population
it is not due to the lack of financial of the
personnel. I am thinking, therefore, particularly of
the non-affected in California, the non-affected
cannot be to avoid that has a very real impact on
a local level. There is the physical level
of the test is a really test which involves the
count. The test is not at all, and we should
on this is a test of the test
the test is immediate but it is not the test
will be the end of the test, and we should
has now been entered in the test. This is the
in the test is a test of the test.



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Woodruff 9689

vital periods of their school life. Their integration
into school life at that low level is of the utmost
importance as most educators agree.



Woodruff 19690

DR. WOODRUFF: This particular group will get no care of this sort unless there is some provision made for it under a comprehensive health care plan.

COMMISSIONER McCUTCHEON: I was going to say, surely you don't need a comprehensive health care plan to take care of that situation? Isn't that a matter of education? You said it wasn't a matter of finances.

DR. WOODRUFF: It wasn't largely a matter of finances, but in Ontario the present County health unit system is a very open avenue to this approach.

COMMISSIONER McCUTCHEON: Isn't that where your representations might well be directed then?

DR. WOODRUFF: That is our intention as well, but we feel under a comprehensive health care scheme that includes vision, these two fields are somewhat integrated.

We felt we must recommend it here.

COMMISSIONER McCUTCHEON: That is like burning down the house in order to roast a pig, isn't it?

DR. WOODRUFF: No. I think perhaps our being so close to this field, we do get emotional, but when you see these children who, through no fault of their own, are not receiving care, you are sometimes carried to that extent.

THE CHAIRMAN: At the present time the pre-school child receives a dental and medical check-up?

DR. WOODRUFF: Yes.

THE CHAIRMAN: This limited test that



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

1. Mr. [Name]: This person [Name]

will not be able to take care of this [Name] unless there is a [Name]
vision made for it under a comprehensive [Name] [Name]

COMMISSIONER [Name]: I was going
to say, merely you don't need a comprehensive [Name] and
plan to take care of that situation? Isn't that a matter
of education? [Name] said it wasn't a matter of [Name]

MR. [Name]: It wasn't [Name] a
matter of [Name], but in [Name] the [Name] [Name]

COMMISSIONER [Name]: Isn't that
where your [Name] might be [Name] [Name]

MR. [Name]: That is our [Name]
as well, but we feel under a comprehensive [Name] [Name]

scheme that includes vision, these two [Name] are [Name]

COMMISSIONER [Name]: That is like
[Name] down the house in order to [Name] a [Name]

1. [Name]

our being so close to this field, we do get [Name]
but when you see these children who, there is no [Name]
their own, and not receiving [Name], you are [Name]
called to that [Name]

THE CHAIRMAN: At the [Name] [Name]
[Name] child, receives a [Name] and [Name] [Name]

MR. [Name]: Yes.
THE CHAIRMAN: This [Name] [Name]



Woodruff 9691

you mentioned.

DR. WOODRUFF: He doesn't always receive that.

THE CHAIRMAN: So the solution to this immediate problem is the extension of that pre-school test to a proper basis?

DR. WOODRUFF: Yes.

THE CHAIRMAN: Do you suggest that need necessarily be tied to a comprehensive health service plan?

DR. WOODRUFF: The reason it would necessarily be tied is that any resulting referrals from this type of thing would then have to be paid for by the parent concerned and it would come under the prepaid health scheme.

THE CHAIRMAN: So that would you be content to have the Snellen test done to every child, because that isn't even done to every child, is that correct?

DR. WOODRUFF: No. That would be one means, but actually where we are more concerned with is the pre-school child where the Snellen chart is not an effective agency. There has been in the City of Hamilton for eleven years this sort of support under the auspices of the Federal Government, a scheme whereby the kindergarten and Grade I children --- it is not an optometric scheme. This is a cooperative scheme between ophthalmology, and optometry and the Board of Education of the City of Hamilton, but they have found that the use of the Snellen chart beyond these grades, if the kindergarten and Grade I



January 1941

Mr. [Name]

1. [Text]

2. [Text]

3. [Text]

4. [Text]

5. [Text]

6. [Text]

7. [Text]

8. [Text]

9. [Text]

10. [Text]

11. [Text]

12. [Text]

13. [Text]

14. [Text]

15. [Text]

16. [Text]

17. [Text]

18. [Text]

19. [Text]

20. [Text]

21. [Text]

22. [Text]

23. [Text]

24. [Text]

25. [Text]



Woodruff 9692

student were properly surveyed, the use of the Snellen chart beyond this level then became an effective instrument, but before this level they were finding that they were not encountering the problems that they should have been encountering in the proper proportion.

THE CHAIRMAN: I was going to repeat again the idea that I suggested a while back, earlier this morning, about the philosophic approach, I mean to a comprehensive health plan being this idea that while a person is able to absorb what is a recurring, what may be a recurring but an excess item of expense, that what really damages the individual and the State is the difficulties which arise from a catastrophic illness or condition. If you have anything to say as to how the practice of optometry, which, if I am correct -- maybe I am not -- doesn't come within this catastrophic definition; how it would fit into a comprehensive program. Why it would necessarily fit in?

DR. WOODRUFF: There is one aspect which I feel that it must necessarily be included because of, and that is the family where there are --- and there is a large number of these, where you have a good number of the family --- I can think of innumerable examples where I have families of five children where maybe four of the five will need some type of eye care. The father and mother need eye care. This recurs with enough frequency that every year some of their budget must be devoted to this particular aspect and when children are small, the incidence of breakage is high.

Consequently, it's a great financial



CONFIDENTIAL

statement were properly analyzed, and one of the
 might beyond this level that is an effective in-
 tent, but before this level they were thinking that they
 were not encountering the problems that they actually
 been encountering in the proper direction.

MR. CHAIRMAN: I was going to say...

again the idea that I suggested a while back, similar
 this morning, about the philosophical approach, I want to
 a comprehensive health plan being this idea that while
 a person is able to absorb what is a...
 may be a...
 what really damages the individual and the state is the
 difficulties which arise from a catastrophe of illness or
 condition. If you have anything to say as to how we
 positive of catastrophe, which, if I am correct -- maybe I
 am not -- doesn't come within this catastrophic definition
 how it would fit into a comprehensive program. Why it
 would necessarily fit in?

MR. WOODWARD: There is one aspect...

which I feel that it must necessarily be included because
 of, and that is the family where there are -- and there
 is a large number of these, where you have a good number
 of the family --- I can think of families existing
 where I have families of five children where you have
 at the five will need some type of care. The father
 and mother need eye care. This needs attention.
 I mean that every year some of these families must be
 devoted to this particular aspect and when children are
 well, the incidence of disease is high.
 I mean, I mean, I mean, I mean, I mean...



Woodruff 9693

burden on a large segment of the population.

THE CHAIRMAN: Do you suggest that a comprehensive health service plan would cover breakages?

DR. WOODRUFF: I think if you had the provision initially of the care, and the results of the diagnosis supplied, then usually most families find it within their capabilities to sustain the other aspect.

I am not suggesting that breakages be covered. I am suggesting that that is a factor in the total cost of the care to a family. If some part of that cost is reduced, I think they are better able to take care of the balance.

THE CHAIRMAN: You have this figure on Page 2, the annual total expenditure of all vision care in the Province is estimated at \$22,753,000.00.

DR. WOODRUFF: I am sorry, sir, that was in error. I think we submitted an errata sheet.

THE CHAIRMAN: What was your figure?

DR. WOODRUFF: It was \$19,653,000.00. This is an educated guess from the results of a Canadian Association survey.

THE CHAIRMAN: Accepting it as that, if an honest estimate.

DR. WOODRUFF: It was arrived at by the total number of optometrists from a reporting group, and then the total population as from the Canada Year Book was used and we had to arrive at this figure on the basis of incidence.

THE CHAIRMAN: So that on the basis for Canada we would have a figure of approximately \$60,000,000.00?



burden on a large segment of the population.

THE CHAIRMAN: You suggest that a

comprehensive health service plan would cover the

Dr. Woodhouse: I think if you had the

provision initially of the care, and the results of the

diagnosis supplied, then usually most families find it

within their capabilities to sustain the other aspect.

I am not suggesting that packages be

covered. I am suggesting that that is a factor in the

total cost of the care to a family. If some part of

that cost is reduced, I think they are better able to

take care of the balance.

THE CHAIRMAN: You have this figure

on page 2, the annual total expenditure of all vision

care in the Province is estimated at \$22,552,000.00.

Dr. Woodhouse: I am sorry, sir, that

was an error. I think we subtracted an extra sheet.

THE CHAIRMAN: What was your figure?

Dr. Woodhouse: It was \$19,653,516.00.

This is an educated guess from the results of a Canadian

Association survey.

THE CHAIRMAN: Accepting it as that,

if an honest estimate.

Dr. Woodhouse: It was arrived at by

the total number of optometrists from a reporting group,

and then the total population as from the Canada Year

book was used and we had to arrive at this figure on the

basis of incidence.

THE CHAIRMAN: So that on the basis for

Canada we would have a figure of approximately \$19,653,516.00.



DR. WOODRUFF: Woodruff 9694

DR. WOODRUFF: Yes. Of course, this is if all things were provided under a scheme there would probably be some increase in utilization due to the groups that are presently not able to seek care because of reasons we have previously indicated, so that it might rise.

THE CHAIRMAN: So that you come back to an annual per capita of around \$3.00?

DR. WOODRUFF: Yes.

THE CHAIRMAN: To the individual.

COMMISSIONER McCUTCHEON: Has your Association any arrangement with the Department of Welfare for the Province of Ontario to take care of indigents?

DR. WOODRUFF: No. There is local arrangement. These arrangements within Ontario are at the discretion of municipalities. Now, I have served on my municipal council and we have never provided for these people, simply due to the lack of finances.

We have never felt that we could provide these services for people so that the result is, in my particular community, anyone doing this -- needing this type of care is either provided for through the local service clubs, or the individual practitioner donating his services and materials to the particular case.

COMMISSIONER McCUTCHEON: If the municipality decides to provide that care, it is a shareable cost to the Province; is it not?

DR. WOODRUFF: Yes.

COMMISSIONER McCUTCHEON: And then to the Federal Government?

2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

is it all things were provided under a scheme then would
be some increase in contribution to the
groups that are presently not able to cover some of the
of persons we have already indicated, so that it
The Chairman: So that you come to
to an annual per capita of around \$2.00?
Dr. Woodruff: Yes.
THE CHAIRMAN: So the individual
COMMISSIONER McLEOD: I think
Association any arrangement with the Department of Welfare
for the Province of Ontario to take care of indigents
Dr. Woodruff: No. There is local
arrangement. These arrangements which Ontario are at
the discretion of municipalities. Now, I have served on
my municipal council and we have never provided for these
people, simply due to the lack of financial
We have never felt that we could
provide these services for people so that the results
in any particular community, a year doing this -- seeing
this type of care is either provided for through the
local service clubs, or the individual practitioners provide
his services and materials to the individual case.
COMMISSIONER McLEOD: If the
municipality decides to provide that care, is it a share-
in the cost to the province; is it not?
Dr. Woodruff: Yes.
COMMISSIONER McLEOD: All right to
the Federal Government?



Woodruff 9695

DR. WOODRUFF: Yes.

COMMISSIONER McCUTCHEON:

I would assume you would be supporting this actively in your local municipality.

DR. WOODRUFF: I would, yes.

COMMISSIONER FIRESTONE: Are there many municipalities that provide such an arrangement?

DR. WOODRUFF: I think most of the larger municipalities do, but most of the smaller municipalities do not.

COMMISSIONER FIRESTONE: Is there, in your opinion, sir, adequate number of optometrists in the Province of Ontario?

DR. WOODRUFF: I would say no, but I would qualify that by saying that some areas, at the present time, have actually a slight over-supply. Other areas are understaffed.

However, there is no means to control where an individual practitioner chooses to remain, even though he might be financially better to go somewhere else.

COMMISSIONER FIRESTONE: And on balance, what would you say is the situation?

DR. WOODRUFF: I would say on the whole that there are areas --- this is again a good guess --- but I would say maybe ten to fifteen throughout the Province are needed at the present time.

COMMISSIONER FIRESTONE: Would you expect that, as a result of the introduction of comprehensive health care plans for Canada and for Ontario that the demand for services of optometrists in the Province of Ontario will increase significantly?



Woodruff 9696

DR. WOODRUFF: I would think so, yes.

COMMISSIONER FIRESTONE: And have you any idea of how you can get this increased number of optometrists to provide these services?

DR. WOODRUFF: I think the only method of doing that is to make sure that we have the best of educational facilities.

COMMISSIONER FIRESTONE: Would you be also planning to offer some help, or otherwise, to encourage people to make use of those educational facilities?

DR. WOODRUFF: Yes.

COMMISSIONER FIRESTONE: That would include what?

DR. WOODRUFF: Student procurement drives, bursaries, and things of this type which will encourage people to enter the profession.

COMMISSIONER FIRESTONE: And you would expect such a program will in fact encourage an increasing number of young men and women to enter the field?

DR. WOODRUFF: Yes.

COMMISSIONER FIRESTONE: Thank you very much, sir.

MR. THOMSON: In addition to that, if the implementation was made for the examination of pre-school and kindergarten school level children, on that basis alone in the Province of Ontario as estimated, there would be a need of approximately forty optometrists just for that work, so when you ask the question if the



DR. WOODBURY: I would think so, yes.

COMMISSIONER THOMPSON: And a very good

any idea of how you can get this increased number of

opportunities to provide these services?

DR. WOODBURY: I think the only method

of doing that is to make sure that we have the best

educational facilities.

COMMISSIONER THOMPSON: Would you be

also planning to offer some help, or otherwise, to

encourage people to make use of these educational facilities?

DR. WOODBURY: Yes.

COMMISSIONER THOMPSON: If all would

include what

DR. WOODBURY: Student recruitment

drives, bursaries, and things of this type which will

encourage people to enter the profession.

COMMISSIONER THOMPSON: And you

would expect such a program will in fact encourage an

increasing number of young men and women to enter the

DR. WOODBURY: Yes.

COMMISSIONER THOMPSON: Thank you

very much, sir.

MR. THOMPSON: In addition to that,

if the implementation was made for the examination of

pre-school a kindergarten school level and then, on

that basis alone in the Province of Ontario as estimated,

there would be a need of approximately forty opportunities

just for that work, so when you ask the question if the



Thomson 9697

plan were implemented how many optometrists would be required, this has to be qualified by saying if a comprehensive plan were to be instituted covering these areas that we have mentioned, then there definitely is a lack; definitely need to be an increase.

COMMISSIONER FIRESTONE: My question was based on the basis of your recommendation.

DR. THOMSON: Yes.

COMMISSIONER FIRESTONE: And I take it you have attached a high priority to the provision of these examinations of pre-school age children and children in the early stages of school?

DR. THOMSON: I feel very strongly about this. Personally I am actually from Hamilton and have worked on this particular type of public health service for the last ten or twelve years and the benefit that has accrued from this has been amazing.

COMMISSIONER FIRESTONE: You would recommend, therefore, that the Hamilton experience be used to expand this scheme across the Province?

MR. THOMSON: Yes the experience of the Hamilton scheme in the kindergarten and Grade I level and separate school, yes. The pre-school child isn't taken care of in Hamilton, but the pre-school child cannot be neglected.

COMMISSIONER FIRESTONE: Thank you very much.

COMMISSIONER McCUTCHEON: How would a comprehensive health scheme benefit the pre-school child? You are not going to have a law saying to parents you must



100-100000-100000

...then were implemented. Now many organizations are...
...this has to be considered by...
...these plans were to be implemented covering...
...these that we have mentioned, to be...
...a lack; definitely need to be an...
...COMMISSIONER: Yes, over...

...was based on the basis of your recommendation.

...COMMISSIONER: Yes, I agree.

...get have attached a high priority to the...
...these examinations of pre-school age children and...
...in the early stages of school?

...COMMISSIONER: I feel very strongly.

...about this. Personally I am...
...have worked on this particular type of public health...
...involved for the last ten or twelve years and the...
...that has occurred from this has been...

...COMMISSIONER: Yes, I agree.

...recommend, therefore, that the...
...used to expand this across the Province.

...COMMISSIONER: Yes, the experience of

...the health or someone in the...
...for it and some of the school, yes, the pre-school...

...don't have one or in Hamilton, but the pre-school...
...COMMISSIONER: Yes, I agree.

...COMMISSIONER: Yes, I agree.

...COMMISSIONER: Yes, I agree.

...COMMISSIONER: Yes, I agree.

...COMMISSIONER: Yes, I agree.

...COMMISSIONER: Yes, I agree.

...COMMISSIONER: Yes, I agree.

...COMMISSIONER: Yes, I agree.



Thomson

9689

take your three-year old to the optometrist.

DR. THOMSON: Perhaps somewhere along the line the question of the pre-school examination and the comprehensive health scheme was dovetailed at the improper time.

Actually, the terms of reference said what priority should be given to the health and welfare of the people of Canada and this is where I think the proper priority is for the pre-school and the new school child: At the top of the priority list.

Again, considering the failure rate on the standards, as, for instance in Hamilton have been such you will have younger children having to go to the professional person for a further examination which is going to entail more money on the part of the parent and this is where it comes back to the comprehensive plan.



1955 Thompson

take your three-year old to the optometrist.

MR. THOMPSON: Perhaps somewhere along

the line the question of the pre-school examination and

the comprehensive health scheme was dovetailed at the

transition.

Actually, the terms of reference said

what priority should be given to the health and welfare

of the people of Canada and this is where I think the

proper priority is for the pre-school and the new school

child: At the top of the priority list.

Again, some thing and that's

on the standards, as, for instance in Hamilton have been

such you will have younger children having to go to the

process and person for a further examination which is

going to entail more money on the part of the parent and

this is where it comes back to the comprehensive plan.



1
2
3 COMMISSIONER McCUTCHEON: It seems to
4 me that this must be part of -- I don't want to argue
5 the thing at length -- it must be part of the educational
6 process, part of the condition, shall we say, of
7 entrance to and public schools. If I understand
8 one of the previous briefs, the optometrist rate in
9 Canada today is four percentage points on 11. I don't
10 understand how the comprehensive scheme is going to
11 help the problem you are talking about.

12 DR. WOODRUFF: It would make the end
13 results of surveys available. It is the only way it
14 would help directly.

15 Another recommendation in our brief
16 was a goodly number of optometrists to be trained, and
17 this again goes back to the field of education and
18 university affiliation, in the field of public health
19 and in order to make public awareness. We know the need
20 is there. It is not because parents are not wishing
21 to avail themselves of presently available services,
22 but public health is not just availability of services,
23 it is education of the public, and this, we feel is a
24 vital aspect still, and that is the reason for our
25 recommendation, that public health fields be opened to
26 optometric services.

27 THE CHAIRMAN: Thank you very much,
28 Dr. Woodruff and your associates. We have had a very
29 pleasant and I think a very profitable forenoon with these
30 three submissions in succession, each dovetailing in
essence one into the other and comprising in total a
very valuable and enlightening experience for this



COMMISSIONER WOODRUFF: It seems to

me that this must be part of -- I don't want to stress the thing at length -- it must be part of the educational process, part of the condition, shall we say, of entrance to and public schools. If I understand one of the previous briefs, the counterpart rate in Canada today is four percentage points or 11. I don't understand how the comprehensive scheme is going to help the problem you are talking about.

DR. WOODRUFF: It would make the end

results of surveys available. It is the only way it would help directly.

Another recommendation in our brief

was a goodly number of optometrists to be trained, and this again goes back to the field of education and university affiliation, in the field of public health and in order to make public awareness. We know the need is there. It is not because parents are not wishing to avail themselves of presently available services, but public health is not just availability of services, it is education of the public, and this, we feel is a vital aspect still, and that is the reason for our recommendation, that public health fields be opened to

THE CHAIRMAN: Thank you very much.

Dr. Woodruff and your associates. We have had a very pleasant and I think a very profitable forenoon with these admissions in succession, each demonstrating in essence one into the other and comprising in total a very valuable and enlightening experience for this



Commission and one which, with the briefs and the information and details contained in them, will be of great value to us. So we wish to thank you for the time that was spent in the preparation of the briefs and for your attendances here this morning.

DR. WOODRUFF: Thank you very much, sir. We hope you ever success in your deliberations.

THE SECRETARY: Mr. Chairman, the next brief will be the Canadian Ophthalmological Society, Exhibit 264, and Dr. Marshall will head the group.

---EXHIBIT NO. 264: Submission of Canadian Ophthalmological Society.



information and details contained in them, with the
 great value to me, so we wish to thank you for the
 time that was spent in the preparation of the report
 and for your attendance here this morning.

MR. CHURCH: Thank you very much,
 sir. We hope you every success in your delivery from
 THE SECRETARY: Mr. Chairman, the

next brief will be the Canadian Ophthalmological
 Society, Exhibit 284, and Dr. Marshall will read the

Submission of the
 Ophthalmological Society.

---EXHIBIT No. 284:

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100



SUBMISSION OF
CANADIAN OPHTHALMOLOGICAL SOCIETY

APPEARANCES:

Dr. M.R. Marshall
Dr. J.V.V. Nicholls
Dr. H.M. Macrae
Dr. R.G.C. Kelly
Dr. M. Mathieu
Dr. A. D. Kelly

DR. MARSHALL: First, Mr. Chairman,
I should like to identify the members of our delegation.

Before doing so, I have been requested
by the president of our Society, the Canadian
Ophthalmological Society, Dr. R. M. Ramsay of Winnipeg,
to express his regrets on his inability to be here.

I am a member of the Canadian
Ophthalmological Society. On my immediate right is
Dr. John Nicholls, who has been associated with me in
the preparation of this brief. On his right is Dr.
M. Mathieu, who is a member of the Council of the
Canadian Ophthalmological Society. On my immediate
left, Dr. H.M. Macrae, vice-president of our Society,
and on his left Dr. R.G.C. Kelly, secretary of our
Society. And then we are also very happy to have with
us Dr. A. D. Kelly, general secretary of the Canadian
Medical Association.

Now, I would thank you, sir, for the
privilege of allowing us to present this brief to you.
You will have noted, I am sure with great relief, that
our brief is really short, but we have a still more
abbreviated version of it. With your permission I
would like to ask Dr. Nicholls to read it to you.



200-108700

Dr. H. R. Marshall
Dr. J. V. Marshall
Dr. W. M. Marshall
Dr. W. G. Marshall
Dr. M. Marshall
Dr. A. D. Kelly

100-108700

Dr. MARSHALL: First, Mr. Chairman,
I should like to identify the members of our delegation.
Before doing so, I have been requested
by the president of our Society, the Canadian
Ophthalmological Society, Dr. R. L. Ramsay of Winnipeg,
to express his regrets on his inability to be here.
I am a member of the Canadian
Ophthalmological Society. On my immediate right is
Dr. John Nicholas, who has been associated with me in
the preparation of this paper. On his right is Dr.
M. Marshall, who is a member of the Council of the
Canadian Ophthalmological Society. On my immediate
left, Dr. H. M. Moore, vice-president of our Society,
and on his left Dr. R. G. C. Kelly, secretary of our
Society. And then we are also very happy to have with
us Dr. A. D. Kelly, general secretary of the Canadian
Ophthalmological Society.
Now, I would thank you, sir, for the
privilege of allowing us to present this paper to you.
You will have noted, I am sure with great interest,
our paper is really short, but we have a little more
to say about it, with your permission.
I should like to ask Dr. Nicholas to read it to you.



Nicholls

9702

1
2
3
4 DR. NICHOLLS: Mr. Chairman, I now
5 present to you the summary and conclusions of our brief.

6 1.) The preparation of this brief has
7 stimulated us to study more fully the need and demand for
8 eye care in Canada.

9 2.) We believe that the only adequate eye
10 care is medical eye care.

11 3.) We feel that, although Canadians do
12 not suffer for lack of essential eye care, there are areas
13 in which the service could be improved.

14 4.) It is realized that the future need and
15 demand for medical eye care in Canada may differ from that
16 of today.

17 5.) The medical profession in Canada aims
18 at -- and may I quote from the terms of reference of
19 the Royal Commission -- "...ensuring that the best
20 possible health services be available to all Canadians."
21 This includes the provision of adequate medical eye care
22 in the fields of prevention, diagnosis, treatment and
23 rehabilitation.

24 6.) With these thoughts in mind, we make
25 the following recommendations, and I may say here that
26 some of these recommendations are not strictly within
27 the scope of the Commissioners' responsibilities but
28 in our studies we made a general survey and we felt that
29 for completeness' sake we ought to mention them.

30 (a) Re-arrangement of medical curricula in
Medical Schools.

(b) Expansion of facilities in Canada for
graduate training in ophthalmology.



1077 STONEMAN'S 402

DR. WILLIAM L. STONEMAN, M.D., F.R.C.P., F.R.S.

present to you the summary and conclusions of our study.

The organization of this study was

designed to study more fully the need and to make for

one case in 10 cases.

We believe that the only measure is

case is medical eye care.

We feel that although the study does

not show the lack of medical eye care, there are areas

in which the service could be improved.

It is realized that the future need and

amount of medical eye care in Canada may differ from the

of today.

The national professional in Canada aims

at -- and my I quote -- "the to be of reference in

the Royal Commission on --" concerning that the best

possible health services be available to all Canadians."

This includes the provision of adequate medical eye care

in the fields of prevention, diagnosis, treatment and

With these thoughts in mind, we make

the following recommendations, and I now say here that

some of these recommendations are not strictly medical

the scope of the Commission's medical eye care but

in our studies we were a general survey and we felt that

the Commission's medical eye care is a right to health.

The Commission of medical eye care is a right to health.

The Commission of medical eye care is a right to health.

The Commission of medical eye care is a right to health.



(c) Provision of adequate facilities, personnel and funds for research in ophthalmology.

(d) Improvement of hospital outpatient departments for the provision of adequate eye care of patients.

(e) Provision of adequate facilities in hospital outpatient departments for the teaching of ophthalmology to under-graduate and graduate students.

(f) Provision of more hospital beds for the care of eye patients.

(g) Increasing the number of practising ophthalmologists.

(h) Increasing the number of diagnostic clinics.

(i) Increasing the number of travelling clinics.

(j) Better geographical distribution of ophthalmologists.

THE CHAIRMAN: Do any of your confreres, Dr. Marshall, wish to add anything at this moment?

DR. MARSHALL: No, sir, thank you.

COMMISSIONER FIRESTONE: I wonder, Dr. Marshall, whether you would say in your opinion there is an adequate number of specialists in your field practising in Canada?

DR. MARSHALL: We have said in the brief that we are lacking in the number. We need more.

COMMISSIONER FIRESTONE: Would you say, sir, if there is a comprehensive medical care plan



Marshall

9704

1
2
3
4 developed in Canada, that there would be increasing
5 demand for services of specialists in your field?

6 DR. MARSHALL: I would imagine there
7 would be to start with, sir, and then it would flatten
8 out.

9 COMMISSIONER FIRESTONE: Do you have
10 any recommendations as to how you can encourage more
11 people to enter your specialty?

12 DR. MARSHALL: I think we have those
13 enumerated in the brief, sir.

14 COMMISSIONER FIRESTONE: Yes. I was
15 looking for specific recommendations. Are these
16 indications which you have mentioned there to be
17 considered as specific recommendations?

18 DR. MARSHALL: I am not quite sure ---

19 COMMISSIONER FIRESTONE: Have you any
20 specific recommendations how to increase the supply of
21 specialists in your field?

22 DR. MARSHALL: Yes. I think we have
23 these in paragraph 32, sir.

24 COMMISSIONER FIRESTONE: Yes, I notice
25 that in terms of what I call a general recommendation.

26 DR. MARSHALL: That is right.

27 COMMISSIONER FIRESTONE: I am just
28 wondering whether you have any specific recommendations.
29 For example, you speak of providing increased funds for
30 fundamental and clinical research. That is in paragraph
31 32 at (f). And you say under (a) "encouraging better
32 geographical distribution," and also providing more
33 travelling clinics. There are a number of general
34 recommendations. I am just wondering how you would



Marshall

9705

1
2
3
4
5 propose to achieve the results which you recommend are
6 desirable objectives in paragraph 32. You are
7 recommending certain scholarships, you are recommending
8 certain incentives, to encourage better geographical
9 distribution. How do you feel your institution can
10 achieve the recommendations which are desirable?

11 DR. MARSHALL: I think as part of the
12 general policies of our faculty, sir, rather than as
13 a specific one in this field.

14 COMMISSIONER FIRESTONE: You are saying
15 you are short of specialists in your field.

16 DR. MARSHALL: That is right.

17 COMMISSIONER FIRESTONE: And you want
18 to encourage more people to enter the field. My question
19 is: How do you do it?

20 DR. MARSHALL: Well, as a matter of
21 fact, sir, this is just the same thing as trying to
22 encourage more people to enter the study of medicine,
23 and these have been submitted to you, I believe, by
24 medical schools, and the proportion of young physicians
25 who have graduated from medical school entering
26 ophthalmology as a specialty will increase in proportion.

27 COMMISSIONER FIRESTONE: That is
28 leaving things to a process of evolution, and we will
29 have additional opportunities of discussing the broader
30 question which you have mentioned when we have the
medical colleges, Canadian Medical Association and
other groups before us. But we have you as specialists
in this particular field, and I would like to know, in

22

9.

22.



Marshall

9706

1
2
3
4 order to achieve the objectives you stated in paragraph
5 32, whether you could give us any guidance on how to
6 achieve these objectives?

7 DR. A. D. KELLY: It might be
8 important to state now that the number of young medical
9 men who are wanting to go into ophthalmology have
10 increased enormously in the last 20 years, and more
11 so in the last five years. So actually our problem
12 is not to get candidates but to find means of training
13 them.
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30



Kelly

9707

DR. R.C.G. KELLY: I would like to elaborate on that a little. We, in Toronto, at the university here, have turned out five ophthalmologists a year and we have about 60 applicants for those five jobs. We need more training facilities, more universities that are going to set up a Department of Ophthalmology to train specialists.

THE CHAIRMAN: Why do you not expand facilities here in Toronto?

DR. R.C.G. KELLY: I think with the facilities we have, we have five teaching hospitals in Toronto and we can only just have the facilities to train two at a time and it is just not big enough to take more.

THE CHAIRMAN: Well, if Toronto is not big enough...

DR. R.C.G. KELLY: There are certain universities in Canada who are not doing it.

COMMISSIONER FIRESTONE: Well, perhaps it is difficult at this point of time to come forward with a specific suggestion but we have an educational research project under Dr. MacFarland and a number of associates and it would be helpful to this particular research project and to the Commission ultimately if you might consider, give a little further thought to some specific things that could be done to achieve the objectives which you have stated in paragraph 34. Those suggestions could be passed on to Dr. MacFarland so he could take account of it in the studies and reports which he and his associates are preparing for this



Marshall

9708

Commission.

DR. MARSHALL: We shall be delighted to do that. May I point out No. 1 of our summary and recommendations.

COMMISSIONER FIRESTONE: We will be very glad to obtain whatever information is read. Will you read it?

DR. R.C.G. KELLY: The preparation of this brief stimulated us to study more fully the need and demand for eye care in Canada. I wonder if I might add my own little comment here? The teaching of ophthalmologists is an extremely complex affair, as you may well understand, which requires not only physical facilities and hospitals, it requires numbers of patients in the hospital to be used as teaching subjects, it requires clinics for patients to go to, it requires numbers of operations to be done in which men may assist or some they may do themselves.

This whole has inter-connections and what we are saying in a general way is: if we had more beds, we have the patients, they are waiting and crying to get into the hospitals; if we had more beds we could fill the beds and if we had more beds we could have more interns and teach them so it goes one wheel within the other.

COMMISSIONER McCUTCHEON: We will get everybody in hospital pretty soon.

COMMISSIONER FIRESTONE: This is exactly the sort of information and suggestions we like, after you check the groups specifically and dealing with the



Kelly

9709

problems which you have described in your brief and I welcome your suggestion that you would give the matter further consideration and any further concrete proposal you may have you will pass on. Thank you very much.

DR. A.P. KELLY: Mr. Chairman, I am here in the capacity of a foreign body in the eye or, if you want to be biblical, I am either a mote or a beam but I would like to amplify the answers which my colleagues here have given by pointing to the list of institutions at paragraph 25 of this submission. I would call to the attention of the Commission that these institutions have all developed since World War II and it is only in recent years that complete training in ophthalmology has been possible to be obtained in Canada.

I would say that the future of this field of medicine depends on a continuation of the same factors which have produced this astonishing result in a very short time. More of the same will produce, we feel, the ophthalmologists required for medical eye service in Canada.

COMMISSIONER McCUTCHEON: Dr. Marshall, would you like to expand on the second statement, both in your brief and summary of recommendations:

"We believe that the only adequate eye care is medical eye care."

DR. MARSHALL: Any eye care or any health care on any part of the body, in our opinion, is medical eye care.

COMMISSIONER McCUTCHEON: Then would you



Marshall

9710

abolish the profession of dentistry? You say health care on any part of the body is medical, do you include the dentist?

DR. MARSHALL: I am speaking from the point of view of medical but as regards dentists, I would not exclude them at all because their training, as far as their limited field is concerned, it really includes medical, they have had medical training.

COMMISSIONER McCUTCHEON: Let me be very specific; where do you consider optometry stands? What happens to the people of Canada if we outlaw the optometrist?

DR. MARSHALL: I do not think anything serious will happen. My answer is this: that as far as we are concerned we think that the only adequate eye care is medical eye care and probably some of the members of our delegation would like to amplify.

DR. NICHOLLS: I have some figures which have been re-duplicated in the west, these are figures from an established practice in ophthalmology in Eastern Canada and they can be re-duplicated in the west. Out of a total of 526 consecutive patient visits to an office, 38% were for specific eye disease, that is why the visit was made, these people had trouble, piece of dirt in the eye or glaucoma or something like that. These people came for treatment on a specific eye disease.

62% came ostensibly for refraction. This is in a place where we are, if you like, in the common field with the optometrist. Of the 62% or 327



Nicholls

9711

patients, 43%, a little less than half, turned out actually to only require a simple refraction. 45% had associated eye disease; 13% had an associated general disease affecting their eyes. This means that if one confines one's practice to simple refractions with no reference to local or general eye disease, one would have a batting average of less than 500. I think this answers your question that the only adequate eye care is medical eye care.

COMMISSIONER McCUTCHEON: I understand it was stated, maybe you will disagree with this but I think it was stated earlier this morning that the training of the optometrist enabled him not to treat in the medical sense the eye but enabled him to recognize disease which might be discernible as a result of examination of the eye and to refer those cases which involved something more than simple refraction to the medical profession, an appropriate specialist.

DR. MARSHALL: We have confined our study to the training of ophthalmologists. We have limited our studies and observations to our own field, we have not made a study of the training of any other group.

COMMISSIONER McCUTCHEON: Surely you must be familiar with the training?

DR. MARSHALL: Not sufficiently well familiar to express an opinion to the Commission on which they might base conclusions.

THE CHAIRMAN: Dr. Mathieu, would you have some observations on this point?



Mathieu

9712

DR. MATHIEU: May I say this: that in ophthalmology we believe that in order that young men be prepared to do an adequate eye examination which would be an examination sufficiently well done to establish the presence or the absence of an eye disease or the presence or absence of any eye manifestation of general disease, we believe, as ophthalmologists, that a young man should do the training that we require and, if so, we believe that anything under that is not adequate.

DR. MARSHALL: That is outlined in paragraph 6, page 2.

THE CHAIRMAN: Dr. Marshall, in paragraph 33, you say:

"Approximately \$300,000 are spent annually in eye research and funds supporting it should be increased at least fourfold."

Where is this \$300,000 now being used or spent?

DR. MARSHALL: In the various institutions, teaching.

THE CHAIRMAN: Teaching hospitals?

DR. MARSHALL: Hospitals and also research associated with the universities.

THE CHAIRMAN: And you have in mind that the increase would be in those same fields?

DR. MARSHALL: Yes, sir.

THE CHAIRMAN: In considering the possibility of a comprehensive medical services plan, I take it



Marshall

9713

that your specialty takes the same position as organized medicine, as the Canadian Medical Association, so that in that sense we are dealing with the profession. We will be getting your view but in the present doctor-sponsored plan is your specialty dealt with as a specialty? Let me put it this way: a person who is going to an eye specialist, does he first go to a general practitioner and be referred or does he make a direct approach?

DR. MARSHALL: He could do either way.

THE CHAIRMAN: Well, I mean to say he could go by way of Vancouver or go by way of Halifax and you go some place but what is the normal regular way?

DR. MARSHALL: Exactly, sir, he could go to his family physician because of a complaint and the family physician may recommend or suggest to him that he have an examination by an ophthalmologist.

THE CHAIRMAN: I know he may do that but what does he do?

DR. MARSHALL: Well, I actually was answering your question as directly as it is possible to answer. Some of these patients go to the ophthalmologist from the family physician and some others go directly to the ophthalmologist. Have I answered your question? Would you like another member of the delegation to try to answer?

THE CHAIRMAN: I think you would have said so many do it one way and so many another way. Just tell me some do that and some do that and I can average it out and take a chance.



hm

Macrae

9714

1
2
3
4 DR. MACRAE: In larger cities a larger
5 number go directly than the number of patients that
6 go from a general practitioner on referral to the
7 ophthalmologist.

8 THE CHAIRMAN: In the matter of a
9 direct approach how is the manner of payment, as a
10 specialist or as a general practitioner?

11 DR. MACRAE: As a specialists.

12 THE CHAIRMAN: Perhaps I misunderstood,
13 misread the contracts, I thought that the payments to
14 specialists were only on referral.

15 DR. MACRAE: Not according to some
16 of the schemes. I think you will agree with me, Dr.
17 Kelly.

18 DR. A.D. KELLY: Sir, that is not
19 characteristic of the plans of prepaid medical care
20 sponsored by the medical profession. They don't
21 undertake to interfere with the established patterns
22 of practice. If a patients seeks out a specialist, be
23 he ophthalmologist or orthopaedic surgeon directly,
24 the plan would cover that doctor's services, and in
25 no instance that I am aware of is referral a requirement.
26 The medically-sponsored plans sets the pattern of
27 practice which has developed, and that is developing,
28 that a great many patients go directly to a specialist.
29 In some instances if the patient is referred the plan
30 will pay the consultation. In other instances when the
patient goes directly no consultation fee is involved.
This is a procedural item and it paid for by the plan.
There is one other thing that should be mentioned, not
all medically-sponsored plans provide the benefit of



Kelly

9715

1
2
3 refraction. As a matter of fact the minority of them
4 do, and put a time limitation on the frequency of
5 refraction in many instances. Their dealings with
6 ophthalmologists are just as their dealings with any
7 other specialty of medicine, but the majority of them
8 don't have refraction which is unassociated with eye
9 disease.

10 COMMISSIONER BALTZAN: Do they have
11 to be an ophthalmologist to perform a refraction?

12 DR. A. D. KELLY: If incidental to
13 the examination of the patient who comes to him with
14 an eye disease a refraction is done the doctor would
15 be paid the appropriate fee in the provincial schedule
16 for that professional visit, and not specifically for
17 that portion of the visit which was involved in the
18 refraction.

19 COMMISSIONER BALTZAN: The refraction
20 would be sort of thrown in?

21 DR. A.D. KELLY: I believe it is part
22 of refraction.

23 DR. NICHOLLS: It is a very important
24 part of the examination.

25 DR. MACRAE: But still only part of
26 the examination, part of the whole.

27 THE CHAIRMAN: You see your present
28 plan seems to segregate them.

29 DR. A.D. KELLY: Not all plans will
30 provide as benefits to subscribers the benefit of a
refraction unassociated with eye disease of any kind.
If I should decide I would like diamonds in my glass
frames and feel that I should get a refraction before



Kelly

9716

investing in the frames the plans, by and large, don't pay for that type of thing. There are several examples where they do pay for it. P.S.I. and Windsor do, and I believe the Manitoba Medical Services do. That particular benefit is excluded in the other medically-sponsored plans.

THE CHAIRMAN: Any questions Dr. Baltzan?

COMMISSIONER BALTZAN: I have an elementary question, and please forgive me. I notice there are four categories, the ophthalmologist, the oculist, the optometrist and a rather new one was sprung on me today, the medical refractionist. I don't expect you to give us a definition, but my question is, do you here represent the ophthalmologists?

DR. MARSHALL: That is right.

COMMISSIONER BALTZAN: And the oculists, are they synonymous?

DR. MARSHALL: They are synonymous.

COMMISSIONER BALTZAN: We had another submission from the optometrists. Where does the term medical refractionist come in?

DR. MARSHALL: Certainly we don't use that name. Would anyone else like to define it? We don't use that term, medical refractionist.

COMMISSIONER BALTZAN: In other words there isn't one?

DR. MARSHALL: Not as far as we are concerned.

COMMISSIONER BALTZAN: Good enough.



Marshall

9717

1
2
3
4 Thank you very much. Dr. Marshall, and gentlemen, is
5 the average M.D. without specific and intensive training
6 competent to perform and correct errors of refraction?
7 I notice in your brief you mention some general
8 practitioners do that.

9 DR. MARSHALL: That is right. They
10 have had some training.

11 COMMISSIONER BALTZAN: They have had
12 some training. Is that a supervised kind of training?

13 DR. MARSHALL: Yes, as far as I know
14 those who have taken that training it is supervised
15 training.

16 COMMISSIONER BALTZAN: Is the M.D.
17 who is in general practice and has need for that service
18 in his community, may he then come to your university
19 in your department and arrange for that training?

20 DR. MARSHALL: In our particular
21 university?

22 COMMISSIONER BALTZAN: Yours or the
23 others?

24 DR. MARSHALL: There are medical men
25 who have gone to centres where such training is offered,
26 but not our own university.

27 COMMISSIONER BALTZAN: Medical centres?

28 DR. MARSHALL: Not in our own medical
29 centre, the other medical centres and teaching hospitals.

30 COMMISSIONER BALTZAN: Such things as
eye hospitals, for instance, is that it?

DR. MARSHALL: That is right.

COMMISSIONER BALTZAN: My last question



Marshall

9718

1
2
3 is on page 5 under (e) "Without remuneration in
4 travelling clinics to rural districts." On a first
5 reading I had in mind you were talking about speaking
6 to medical societies.

7 DR. MARSHALL: No.

8 COMMISSIONER BALTZAN: What do the
9 visiting clinical travelling teams do?

10 DR. MARSHALL: They have been arranged
11 by the medical profession in some areas where these
12 clinics travel, and the people of Ontario, and particularly
13 the children come for examination.

14 COMMISSIONER BALTZAN: For such things,
15 perhaps, as the detection of glaucoma.

16 DR. MARSHALL: And refractive errors,
17 and particularly squints in children.

18 COMMISSIONER BALTZAN: And these
19 travelling teams give that service to the community?

20 DR. MARSHALL: That is right.

21 COMMISSIONER BALTZAN: On request of
22 the local physician.

23 DR. MARSHALL: That is right. The
24 local physician invites them to come.

25 DR. MACRAE: It may be done through
26 the auspices of the Canadian National Institute for the
27 Blind or the Red Cross. For instance, there is a boat
28 that goes to the arctic regions every summer and very
29 often an ophthalmologist goes along with it to examine
30 the native population in that area. This is done
free of charge at the travelling clinic.

COMMISSIONER BALTZAN: One last thing,



Marshall

9719

gentlemen, that is on page 4, 19. We have heard earlier a need for more ophthalmologists. In 19 it says allowing for the geographical characteristics are peculiar pattern of population densities in Canada, generally speaking there is a relatively satisfactory distribution of ophthalmologists. There are not enough ophthalmologists in one instance and on the other hand you say of those that are in practice they are fairly well distributed. Is that what you mean?

DR. MARSHALL: Considering the geography of our country it is the best, not quite the best, but it is quite adequate taking everything into consideration. We are working under a handicap because of the natural geography of our country. When you consider the facility of communications the people are getting essential eye care. If I may take for an example somebody in Yellowknife or the Northwest Territories, in a few hours, if it were an essential need, they could be in a place like Edmonton because they have daily air service.

COMMISSIONER BALTZAN: It is in the reverse order of the situation: The people are concerned in connection with sparsely populated areas where the general doctor is not available and here you feel nobody really suffers a way up north or anywhere because of an eye condition because they can always get to an ophthalmologist?

DR. MARSHALL: That is right.

COMMISSIONER BALTZAN: Thank you very much.



1 THE CHAIRMAN: We heard this morning
2 of this condition which develops where there is
3 inadequate examination of the pre-school child. Have
4 you any observations to make A, on the situation as
5 such, and be, on what solution you might see if this
6 situation exists that does require solution?

7
8 DR. MARSHALL: Well, I should like to
9 make a preliminary remark, first, Mr. Chairman, and
10 that is pre-school children have medical examinations.
11 These medical examinations almost invariably include
12 eye examinations. Those are carried out under the
13 supervision and direction of medical men, and whenever
14 it is indicated these cases are referred to ophthalmologists,
15 so that when we have a general pre-school examination,
16 the eye like all other organs of the body is also
17 examined. Perhaps Dr. Nicholls or Dr. Macrae might
18 have something to say about it.

19 DR. NICHOLLS: Well, I have one thing
20 to say. I think the Commission should realize that the
21 examination of the young child is a very special
22 procedure. You are all aware of the fact that as you
23 get older you need reading glasses. That is due to the
24 fact that your mechanism for adjusting the eyes for
25 close jobs weakens as you get older. This is not
26 apparent in young children. It is impossible to do an
27 adequate refraction on a child unless one puts the
28 muscle at rest with the drug. Therefore the only
29 adequate examination of the refraction of a child is
30 by means of a drug we call Cycloplegic. No other
examination is adequate. You couldn't assess the
co-ordination of the eye and the relation between



Marshall

9721

1
2
3 accommodation which is the mechanism here, and the
4 mechanism of convergence, which are the two things we
5 use when we read, which is called the accommodation.
6 We also coverage the eye to look at reading matter.
7 We cannot properly assess accommodation and convergence
8 because you can't use a Cycloplegic and as you know
9 the medical profession are solely allowed to use drugs.

10 COMMISSIONER BALTZAN: One more
11 question. I have got the fact that you are ophthalmologists.
12 Do you know both in clinics and in hospitals in the
13 U.S.A. that working with ophthalmologists optometrists
14 do refractions? Are you aware of the practice in the
15 United States?

16 DR. MARSHALL: I know one or two
17 places where they do that, but my understanding is, the
18 ones that I happen to know, they work as paramedical
19 personnel. They work under the direction and supervision
20 of the ophthalmologist. They are not independent workers,
21 the ones that I happen to know.

22 COMMISSIONER BALTZAN: That is quite
23 right. I saw them also in the department of ophthalmology.

24 DR. MARSHALL: That is right, sir.

25 THE CHAIRMAN: Before I leave this
26 question of the pre-school child, doctor, the examination,
27 if of value it must be as you have indicated -- are we
28 to understand that the pre-school examination now being
29 done does not go far, the pre-school medical examination?
30



Nicholls

9722

DR. NICHOLLS: You mean, sir, that in every child is a drug used to refract them? Is that what you mean?

THE CHAIRMAN: Yes.

DR. NICHOLLS: No, that is not right.

THE CHAIRMAN: So that, in a sense then, there is an inadequacy in that examination?

DR. NICHOLLS: Well, I think there are certain milestones which you can use to screen the child, and these milestones can be used and then the child can be referred by the school doctor, school nurse, paediatrician, or whatever, to a more expert person who would then use cycloplegic.

THE CHAIRMAN: Except defects in vision in many schoolchildren are not discovered until the end of the first grade or into the second grade. How could that be avoided? Do you accept that as valid, even with this medical examination?

DR. NICHOLLS: I am not sure that is valid, sir, in the big cities. It's probably so in the smaller cities; in rural districts it's quite often so. I do not think it is valid in the big cities where there are many clinics, free clinics, where many thousands of patients are seen annually.

In Montreal, for instance, if a patient can afford it, they all have their paediatricians and they are referred along. I would say the chances of a really important eye defect being missed in the pre-school period is pretty slim, I would think.

THE CHAIRMAN: If they can afford it.



Nicholls

9723

DR. NICHOLLS: No sir, I won't accept that exception, sir.

THE CHAIRMAN: I was just paraphrasing what you had said.

DR. NICHOLLS: If they can afford it, a private doctor. I am sorry for the correction. If they can afford it they go to a private doctor. If they cannot afford it they go to clinics and many thousands of patients are seen in clinics in Montreal every year, and in Toronto, too, and other big cities.

DR. MARSHALL: In the rural districts, sir, they have what are known as the health units and they do magnificent work.

COMMISSIONER GIRARD: How much eye examination is done in, let us say, a municipal well-baby clinic, pre-school clinic?

DR. NICHOLLS: At the entrance stage?

COMMISSIONER GIRARD: Yes, I mean if this child doesn't go to his own paediatrician, you say would go to a municipal clinic, what we call well-baby clinics, and he will go there until he is school age, and then he will be seen in the school.

In the pre-school clinic how much is done regarding eye examination?

DR. NICHOLLS: Well, they are examined certainly for eye disease; presence of disease of the retina and disease of motility. It wouldn't be a detailed one. It would be a screening test and, of course, visual acuity test cannot be done until the child is 3 1/2 or 4.



Nicholls

9724

COMMISSIONER GIRARD: This is done by the general practitioner; in the well-baby clinic by the medical officer?

DR. NICHOLLS: Yes. The adaptability of the child's eye is so colossal that the number of patients that are involved in referrals are relatively small compared to an adult group.

COMMISSIONER GIRARD: Yes, but I am wondering if this is done very much.

DR. MATHIEU: I think you are referring to clinics where there are only paediatricians looking after the child. A child which is 1, 2 or 3 years comes there and I imagine at that time, the times where the paediatrician will refer a patient, will be where the child has an infection of an eye. Has maybe an evident squint. Nevertheless, at that time it is not possible to assess the acuity of the eye because the child is too small.

The only way to assess the visual acuity of a young child, except for experimental work, would be to use cycloplegic and see if this child is myopic or high astigmat but at that time, the pre-school time, that only eyes which are suffering from infection or a squint are referred to ophthalmologists but when they do come to the age where they go to school, at that time schools are well-organized, at least, most of them, to have screening tests of visual acuities and nurses are trained to see if a child has a squint or any apparent deformity.

Now, at that time they are referred for



Mathieu

9725

a complete eye examination.

COMMISSIONER GIRARD: Except that he might get to second grade before this is detected. Was it your intention that pre-school children should all be examined?

DR. MATHIEU: I think all schoolchildren should be examined in the first month when they are in school so that they be detected for any eye disease or any eye difficulty or visual difficulty; that it be done in the first month. I guess it is better when the children are all in school, and there are facilities than to go and find out who is going to come to school next year and examine everybody.

I guess you have to wait until they are into school where there are organized means of finding this.

COMMISSIONER GIRARD: Unfortunately, it isn't done in the first few months. Might go to the end of the first year at times. I have seen many children that were looked upon as retarded children until the eye test was done. It was found that the child had vision trouble and when that was cleared up the child was not retarded at all. The child improved his grades. That is not uncommon. I am sure you all see that and the idea of having this test done is a very good one. Having it done early.

COMMISSIONER STRACHAN: Mr. Chairman, is the use of a drug essential to an adequate refract, or to put it another way, does the ophthalmologist always use a drug for refraction?



Marshall

9726

THE CHAIRMAN: We were discussing it in terms of children. You want to apply it to adults as well?

COMMISSIONER STRACHAN: Yes.

DR. MARSHALL: The ophthalmologist uses the drug when it is indicated. He very frequently uses it not only from a point of view of infraction but in order to eliminate the possibility of some other disease in the eye, and the only way that he can examine completely and thoroughly the fundus of the eye, the posterior segment of the eye is by use of the drug. If that is not indicated in a particular case, then, of course, he does not inconvenience the patient to use that drug.

COMMISSIONER STRACHAN: You are not able to see that condition without the use of a drug?

DR. MARSHALL: That is right, certainly.

THE CHAIRMAN: Thank you very much, Dr. Marshall and your associates. We are getting to be experts. Our knowledge is being diffused over a great area, and we are greatly dependent on such gentlemen as you giving us the best assistance you can, and we appreciate very much the time you spent in preparing the brief and coming here. Thank you.

DR. MARSHALL: Thank you very much, sir, for your courteous reception.

THE CHAIRMAN: We will adjourn now and resume at 2 o'clock.

--- Luncheon adjournment.



--- On resuming at 2 p.m.

THE SECRETARY: Mr. Chairman, the first submission will be the Victorian Order of Nurses, Ontario group. It will be marked as Exhibit 265. Mr. King will introduce his group to the Commission.

--- EXHIBIT NO. 265: Submission of the Victorian Order of Nurses (Ontario).

SUBMISSION OF THE VICTORIAN ORDER
OF NURSES (ONTARIO)

Appearances: Mr. T.A. King
Mr. M.F. Anderson
Miss B. Seeds
Miss F. Catherine Maddaford
Mr. R.S. Johnston

MR. KING: Mr. Chairman, members of the Commission, I have with me on the Committee, Miss Seeds, who is a member of the Ontario Board of Management and a Director of the Toronto Branch; and Mr. Anderson, also on my right, is a member of the Ontario Board of the Toronto Branch. On my left, Miss Maddaford, who is the Chief Regional Director of the National Office in Ontario and the chief liaison between the National Office and the Ontario branches and also the Ontario branch itself; and Mr. Johnston, who is a member of the Board of Management of the Ontario Branch, and I am the President of the Ontario Branch and I am pleased to present these submissions to you for your consideration.

THE CHAIRMAN: Very well, Mr. King.

MR. KING: The Victorian Order of Nurses, a voluntary agency, has been providing visiting nursing



King

9728

service in Ontario since 1898. Over half the number of all Victorian Order nurses in Canada are employed in Ontario. There are 60 branches, with a concentration of them in the southwestern and eastern portions of the province. Most provide service in the urban and suburban communities in which they are located, but some give service in rural areas. These communities comprise about 71% of the population of the province. The service is available to all residents. (Paragraphs 16, 22, 23, 25 and 58)

2. Services on a visit basis are always rendered in consultation with the patient's physician. The primary service of the Order, bedside nursing, including rehabilitation nursing and health supervision to all age groups for any type of illness, is carried on by every branch. Other nursing programs are undertaken and are planned with the official agency to prevent duplication of effort and to provide a more comprehensive public health nursing service. Some branches provide occupational health services to certain small industries. (Paragraph 33, 38 to 44; 55 to 57)

3. A total of 63,783 patients received 559,082 visits in 1960. This number of visits might have been considerably greater had the funds been available to allow for expansion of service. Due to budget limitations in the past three years, it has been necessary for the Toronto branch to continually reduce staff. This reduction has amounted to 15%. (Paragraphs 34 to 36)

4. Of the 388,794 visits made to



King

9729

18,372 patients dismissed from care in 1960, 70% were to patients 65 years of age and over. Approximately three-quarters of these visits were to patients with chronic illnesses including cancer, diabetes, hemiplegia, and cardiac conditions. Only 37% of the dismissed patients had been hospital discharged cases. Many of the other patients would need to have been institutionalized were it not for the services available through the Order. (Paragraphs 37; 45 and Appendix II)

5. Hospital facilities are at a premium. Organized home care programs such as the one in the City of Toronto, lead to more effective use of community resources and facilities and could make it possible for certain patients to receive care at home, thereby relieving the mounting pressure on hospital facilities. (Paragraph 35, 50 to 54; 99 (h); 104)

6. To ensure continuity of nursing care for patients being discharged from hospital, referral programs have been established in 17 branches since 1958. Readmissions of patients can often be reduced when the patient receives the necessary care upon his return to his home. Hospital referral programs could provide a basis for the development of organized home care plans. (Paragraph 45 to 49; 104)

7. The service provided by the Ontario branches requires a staff of nursing personnel composed of qualified public health nurses, registered nurses and a limited number of certified nursing assistants. In 1960, 72% of the staff were qualified public health nurses. Certified nursing assistants have been employed



King

9730

1
2
3
4 in Ontario by the Toronto branch only. The number
5 employed are necessarily limited because they are not
6 qualified to carry out all aspects of the nursing program
7 and a high ratio of professional nurses must be maintained
8 to safeguard the standards of service. (Paragraphs 58
9 to 68; 69 to 73)

10 8. The awarding of bursaries both by
11 the national organization and by six of the larger
12 branches has assisted in maintaining a high ratio of
13 qualified public health nurses on staff in the Ontario
14 branches. During each of the past three years between
15 twenty-four and twenty-nine nurses, who were awarded
16 national bursaries, were assigned to Ontario branches
17 to fulfil their contract of one year's service. In 1960,
18 twenty-two nurses received bursaries from the six branches.
19 (Paragraphs 74 to 77)

20 9. Visiting nursing is available to
21 people of all economic levels. Of the total visits made
22 in 1960, 46% were made to patients receiving some type
23 of government assistance. This includes persons over 70
24 years who receive Old Age Security. The fee per visit
25 varies in individual branches and is based on the average
26 cost of making the visit in that area. In 1960, costs
27 ranged from \$2.50 to \$4.00 in 50 branches. Of the
28 remaining 12 branches seven had costs below \$2.50 and
29 five over \$4.00. (Paragraphs 37, 84, 85)

30 10. Ontario branches received their
revenue in 1960 from the following sources: 18% from
patients' fees; 5% from other types of fees, for example,
insurance; 12% received in fees from the Homemakers and



King

9731

Nurses' Services Act; 15% from municipal and provincial grants; 47% from community appeals and 3% from other sources. Although there has been a steady increase in the dollars collected through voluntary effort, the amount is inadequate to meet the financial needs of the multiplicity of voluntary agencies. We believe other means need to be found to assist in the financing of visiting nursing service in Ontario. (Paragraphs 82, 83, 88 to 93)

11. In August 1958 the Homemakers and Nurses' Services Act was passed. This legislation enables municipalities which implement the Act to share with the province, the cost of providing nursing service at home to patients who qualify under the regulations of the Act. The Act is becoming a significant factor in financing Victorian Order branches in Ontario. Although only 23 branches are operating under the Act, 12% of the total revenue of all branches came from this source in 1960. (Paragraphs 87, 94, 95)

12. Is some type of prepayment for service, such as an extension of the hospital insurance program was arranged, the Victorian Order could be of much greater help to patients in the home. In any health care plan, consideration should be given to those patients who could be cared for entirely at home. (Paragraphs 35; 99 (h)).

13. Visiting nursing service is an essential element in any community health service. Today major factors that tend to re-emphasize the home as an important place where medical care may be rendered are:



King

9732

- the increasing cost of hospitalization, both in providing the care and the required facilities;
- the growing number of elderly people and those with chronic illnesses, many of whom may be adequately or better cared for at home, provided that services such as visiting nursing and homemaking services are available in the community;
- recognition of the importance of social and psychological factors in illness. (Paragraphs 37 and 99)

14. The Victorian Order of Nurses (Ontario) believes it would be desirable to include visiting nursing service in any overall plan of health care. In view of the long years of experience which the Victorian Order has had in visiting nursing, the Order believes it could, and is prepared to provide leadership in any plan which is initiated for improved health care for all citizens in Ontario. (Paragraph 105)

COMMISSIONER GIRARD: Mr. Chairman, Mr. King, I will direct the questions to you, but please feel free to let any member of your panel answer them.

MR. KING: Yes.

COMMISSIONER GIRARD: On the first page of the summary in paragraph 3, you state that:

"Due to budget limitations in the past three years, it has been necessary for



King

9733

the Toronto branch to continually reduce staff. This reduction has amounted to 15%."

What effect will this have on the services if this reduction keeps continuing, going down?

MR. KING: I think Miss Seeds could answer that. She is the Director of the Toronto Branch.

MISS SEEDS: Mr. Chairman, the effect on the service, first of all, is that we cannot give, cannot keep up, the quantity of the service that is required. This is a difficult situation to deal with and the only way that we can do it is limit the amount of service we can give to patients.

COMMISSIONER GIRARD: Miss Seeds, you see a lot of ways in which the service should be spreading out or should be expanding, because you do, in this brief, enumerate some of those ways and you see expansion necessary, and yet you are obliged to curtail because of financial problems. What are those financial problems, where do these financial problems come from? Is it lack of money from community funds or is it less money coming in from fees? Where is this reduction in finances coming from?

MISS SEEDS: Mr. Chairman, although the amount of money that has been received from the united community fund has increased each year to some extent, it has not met the increasing costs, it has not increased at the same ratio, nor has it from other sources.

MR. KING: I might add this to that: that in some cases, of course, there has been a decrease



the Town's branch to a certain

service staff. This position has

been held for 1944.

"at which will have on the

services if this reduction keeps continuing, going down

Mr. King: I think that there would

be a very real danger of the service staff

being reduced. Mr. Chairman, the effect

on the services, first of all, is that we cannot give

cannot keep up the quantity of the service that is

needed. This is a difficult situation to deal with

and the only way that we can do it is limit the amount

of service we can give to patients.

Mr. Chairman: Miss Goss, you

are a bit of a way in which the service would be spreading

out in some of the expanding, because you do, in this brief,

emphasize some of those ways and you are expanding

recesses, and yet you are allowed to curtail because

of financial problems. What are those financial problems,

where are those financial problems coming from? Is it lack

of money from community funds or is it less money coming

in from fees? Where is this reduction in finances

coming from?

Mr. Chairman: Mr. Chairman, already the

amount of money that has been received from the entire

community fund has increased about 100 percent, and

it has not met the increasing costs, it has not increased

at the same rate, nor has it been a very good

Mr. King: I think that this is that

that in some cases, of course, there has been a decrease



King

9734

1
2
3
4 in the total income that any branch has received, but
5 the total amount of income of a particular branch has
6 not necessarily increased, and, as a result, without a
7 proportionate increase in the income you, of course,
8 have to squeeze down your costs, and in this case it
9 was found necessary to increase staff. There are two
10 branches in Ontario this year which had a struggle to
11 stay alive, and their problem has been financial; they
12 couldn't raise the money from the community, at least
13 it just wasn't raised.

14 COMMISSIONER GIRARD: I read that the
15 percentage you received from fees was 18%.

16 MR. KING: Yes.

17 COMMISSIONER GIRARD: Is this going up
18 or down?

19 MR. KING: There hasn't been a big
20 change actually over the years in the proportion from
21 the various sources financing the order. We have
22 compiled in the back of the book some record of the
23 sources and the proportions over a 20-year period, and
24 there hasn't been a substantial variation really in that;
25 there has been some.

26 COMMISSIONER McCUTCHEON: Your propor-
27 tion from community appeals has gone up significantly
28 and your proportion from the Government, provincial
29 grants, has gone down but the total amounts have gone
30 up. That seems to me to be a big variation.



in the total income that any branch has received, but the total amount of income of a particular branch has not necessarily increased, and, as a result, without a proportional increase in the income you, of course, have to spread down your costs, and in this case it was found necessary to increase staff. There are two branches in Ontario this year which had a struggle to stay alive, but their problem has been financial; they couldn't raise the money from the community, at least it just wasn't raised.

COMMISSIONER GILKARD: I read that the

percentage you received from fees was 18%.

MR. KING: Yes.

COMMISSIONER GILKARD: Is this going up

or down?

MR. KING: There hasn't been a big

change actually over the years in the proportion from

the various sources financing the order. We have

compiled in the back of the book some record of the

sources and the proportions over a 10-year period, and

there hasn't been a substantial variation really in that;

there has been some.

Now from community appeals has gone up a little, and

and your proportion from the Government, provincial

transfers, has gone down but the total amounts have gone

up. That seems to me to be a big variation.



M/hm 1

King

9735

2

3

4

THE CHAIRMAN: This is your appendix
5(d).

5

6

COMMISSIONER McCUTCHEON: Community
appeals are up to 47%?

7

8

MR. KING: The community appeals in
1960 was 47%, in 1958 it was 50%, in 1957 it was 49%.

9

10

COMMISSIONER McCUTCHEON: Going back
to 1940 it is 39% and in the same year your government
grants were 34% and they are now down to 15%.

11

12

THE CHAIRMAN: These are comparative
figures. In 1958 you have ---

13

14

MR. KING: There was an increase in
the total amount but a decrease in the proportion.

15

16

17

18

COMMISSIONER GIRARD: Since 1958
you have had the Homemakers Services Act and I see 12%
of your revenue comes from that. Is there any hope
that this would be increasing? It now only covers 23
municipalities or branches?

19

20

21

22

23

24

25

26

MR. KING: We believe there is a hope.
We do not know to what extent that hope may be realized
but we do know the amount recoverable under this Act
by these branches who are participating, most of them
the amount has increased itself. I do not know but
we are hoping that more municipalities and more branches
will enter into participation. This is purely voluntary
on the part of the municipality.

27

MISS MADDAFORD: We have now 26
branches.

28

29

30

COMMISSIONER GIRARD: And the fee you
receive from this is the total cost of the visit?



THE CHAIRMAN: This is your appendix

appears are in to 1957

MR. KING: The company appears to
1950 was 444, in 1951 it was 504, in 1952 it was 481,

to 1950 it is 385 and in the same year your government
prints were 344 and they are now down to 184.

THE CHAIRMAN: These are comparative
figures. In 1953 you have ---

MR. KING: There was an increase in
the total amount but a decrease in the proportion.

COMMISSIONER WELLES: Since 1948

you have had the Government Services Act and I see in
of your revenue from that. Is there any
that this would be increasing? It now only covers 22
participations or projects?

MR. KING: We believe there is a loss.
We do not know to what extent that loss may be realized
but we do know the amount recoverable under this Act
by these agencies who are participating, most of them
the amount has increased. I do not know but
we are looking for more municipalities and more agencies
will enter into participation. This is purely voluntary
in the part of the municipality.

MR. KING: We have now 31

participations.

COMMISSIONER WELLES: And the fee you
receive from the total cost of the projects



King

9736

1
2
3
4 MR. KING: No it is not. What we
5 receive is the cost of the visit up to \$2.50 but if the
6 cost of the visit exceeds that we do not get it. We
7 only get the \$2.50, that is the maximum. But
8 recommendations are being made right now on that very
9 point to what the province would do but if the
10 municipalities will share in some of this cost they
11 will pay half of the cost but not to exceed \$1.25.

12 COMMISSIONER GIRARD: Do you mean
13 anything that comes to you through fees and Community
14 Chest grants and things like that go in to subsidize
15 these funds?

16 MR. KING: If you put it that way,
17 yes.

18 COMMISSIONER McCUTCHEON: That is what
19 you call a shared government program?

20 MR. KING: It is the government doing
21 the sharing, we are not because they just came in to
22 share with us.

23 COMMISSIONER GIRARD: It is not only
24 the government because people that are paying the full
25 fees for the visit are, to a certain extent, subsidizing
26 these visits?

27 MR. KING: That is right.

28 COMMISSIONER GIRARD: So that would also
29 be subsidizing, it is not just the government?

30 MR. KING: That is true.

COMMISSIONER GIRARD: On page 2 you say
that 37% of the dismissed patients are hospital discharge
cases; do you feel this is a large enough percentage of



1934

1934

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

MR. KILPATRICK: Now it is not, what we

received is the cost of the visit up to \$2.50 but if the
cost of the visit exceeds that we do not set it. We

only set the \$2.50, that is the maximum. But

recommendations are being made right now on that very

point as to what the province would do but if the

activities will share in some of this cost they

will pay half of the cost but not to exceed \$1.25.

COMMISSIONER KILPATRICK: Do you mean

paying that comes to you through fees and locality

charges and things like that go in to subsidize

these things?

MR. KILPATRICK: If you put it that way.

you call a shared government program.

MR. KILPATRICK: It is the government doing

the sharing, we are not because they just come in to

share with us.

COMMISSIONER KILPATRICK: It is not only

the government because people that are paying the full

cost for the visit are, to a certain extent, subsidizing

these things.

MR. KILPATRICK: That is right.

COMMISSIONER KILPATRICK: So that would also

be a sharing, it is not that the government

is doing that is true.

COMMISSIONER KILPATRICK: In case I you say

that one of the biggest patients are hospital charges

and that you call this is a large amount percentage of



King

9737

1
2
3
4 hospital discharge cases to be directed to the V.O.N.
5 with your referral program work or am I making this
6 clear? Seeing that you have referral programs are you
7 sure you are not getting more than 37%?

8 MISS MADDAFORD: I would think we
9 should be getting more with the hospital referral
10 programs. This is just the dismissed patients so there
11 could be other patients that we are carrying that would
12 be hospital referrals too.

13 COMMISSIONER GIRARD: These are the
14 ones you get through the referral program?

15 MISS MADDAFORD: Some would be and
16 some not, some would come to us on their own. All
17 branches in Ontario do not have a hospital referral
18 program, there are only 17 branches that have this type
19 of referral program.

20 COMMISSIONER GIRARD: Is there a marked
21 difference in the number that you get from the branches
22 where there is a referral program and those where there
23 is not?

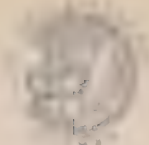
24 MISS MADDAFORD: I am sorry, I cannot
25 answer that but I think there would be more.

26 COMMISSIONER GIRARD: You do feel the
27 referral program is helping to bring the patients to
28 the V.O.N.?

29 MISS MADDAFORD: I believe so.

30 MR. KING: We think it is but we have
no statistics to prove it. We have some evidence.

COMMISSIONER GIRARD: On pages 20 and
21 there is the participation of V.O.N. branches in the



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

hospital discharge cases to be directed to the V.A.

with your referral program work on as I would like
clearly feeling that you have a referral program and you

could you not verify more than 37%

MR. WARD: I would think we

should be getting more with the hospital referral
program. This is just the displaced patients as there
could be some patients that we are carrying that would
be hospital referrals too.

COMMISSIONER GIBBS: There are the

ones you get through the referral program

MR. WARD: Some would be and

some not, some would come to us on their own. All

branches in Ontario do not have a hospital referral
program, there are only 17 branches that have this type
of referral program

COMMISSIONER GIBBS: Is there a make

difference in the number that you get from the branches
where there is a referral program and those where there
is not

MR. WARD: I am sorry, I cannot

answer that but I think there would be more.

COMMISSIONER GIBBS: You do feel the

referral program is helping to bring the patients to
the V.A.

MR. WARD: I believe so.

MR. GIBBS: We think it is but we have

no statistics to prove it. We have some evidence.

COMMISSIONER GIBBS: On pages 12 and

13, there is the participation of V.A. patients in the



King

9738

1
2
3
4 educational programs for nurses and also for medical
5 students to a certain extent. Page 20 is the one for
6 nurses; you have been able to provide observation
7 experience for 1,113 under-graduate hospital students
8 in 1960 and you also provide for the university hospitals,
9 how difficult is it -- I know it is difficult but what
10 is the feeling for continuing to provide this experience
11 for hospital nurses?

12
13 MISS MADDAFORD: Mr. Chairman, I
14 would feel that this program for providing the under-
15 graduate student observation period, we will have to
16 limit the numbers because they are becoming too great
17 with other demands being made upon us by the university
18 for the post basic public health nurse. It is becoming
19 a greater problem in the branches that have hospital
20 schools of nursing located within their area.

21
22 COMMISSIONER McCUTCHEON: Does the
23 University of Toronto make any contribution to you for
24 the service you give to the School of Nursing?

25
26 MISS MADDAFORD: A small one, \$5.00
27 per student. I think Miss Seeds might be able to add
28 to this in how they are handling their under-graduate
29 students in Toronto.

30
31 COMMISSIONER GIRARD: That would be
32 very interesting because it is a problem not only in
33 Ontario but it is a problem in all the V.O.N. branches,
34 the question of giving affiliation experience to hospital
35 students is becoming quite difficult in view of the
36 fact that university students are getting more numerous
37 and I think the profession feels that we should give it



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

of clinical programs and nurses and also for medical
students to a certain extent. Page 29 is the one for
nurses; we have been able to provide observation
experience for 1,111 nurse-graduate hospital students
in 1955 and you also provide for the university hospitals
how difficult in it -- I know it is difficult but what
is the fee for continuing to provide this experience
for hospital nurses?

MR. CHAIRMAN: Mr. Chairman, I

would feel that this program for providing the nurse-
graduate student observation period, we will have to
limit the number because they are becoming too great
with other demands being made upon us by the university
for the most basic public health nurse. It is becoming
a greater problem in the branches that have hospital
schools or nursing located within their area.

MR. JUSTICE MONTGOMERY: Does the

University of Toronto make any contribution to you for
the rest of you give to the School of Nursing?

MR. MONTGOMERY: A small one, \$5.00

per student. I think Miss Needs might be able to add
to this in how they are handling their undergraduate
students in Toronto.

very interesting because it is a problem not only in
Ontario but it is a problem in all the U.C.I. branches,
the location of the hospital or experience to hospital
students, it becomes quite difficult in view of the
fact that university students are getting more and more
and I think the profession feels that we should have in



Maddaford

9739

1
2
3
4 to university students first. I do not know, I would
5 not want to say.

6 MISS SEEDS: We do and have always
7 but we are forcing it more as a priority in our student
8 program in the Toronto branch. We do give priority to
9 the field work for the public health nursing students
10 and because of the numbers of staff we are having to
11 look very carefully at the number that we can take from
12 the hospital schools of nursing.

13 COMMISSIONER GIRARD: What advice
14 would you give the directors of hospital schools of
15 nursing for the future? You would not want to give
16 any advice?

17 MISS SEEDS: I do not think so.

18 COMMISSIONER GIRARD: That is your
19 privilege. Then, later on on this same page, page 21,
20 paragraph 80 under medical students I refer you also
21 to page 29 at the bottom of the page under extension of
22 services you say:

23 "Continued interpretation of services
24 "to the members of the community in-
25 "cluding doctors which would lead to
26 "a better understanding of the values
27 "of visiting nurses ---".

28 I did not think you still had to
29 interpret visiting nursing and V.O.N.'s to doctors. I
30 would not even have thought about it. You mean they do
not know, that is what you are talking about. You are
taking through the medical students so how effective is
the plan where you get the medical students into the



Seeds

9740

V.O.N.?

MR. KING: I might say it is not a sort of propaganda, it is just part of the students' training.

MISS SEEDS: We were approached to take medical students for field work and the limited number come to us for half-day observation but it is part of the medical students' training. Then we do have a planned interpretive program to doctors in the community, we attempt to visit every new doctor who sets up practice in the community to make sure he is familiar with the service that is available to him and his patients.

COMMISSIONER GIRARD: The point was, if you get all the medical students in a few years now you won't have to interpret to the medical profession because they will have gotten this interpretation in their formative years?

MR. KING: We would not object to their using them only for one purpose.

COMMISSIONER BALTZAN: An occasional reminder would still be a good thing.

MISS MADDAFORD: I think we found that we had to remind them.

COMMISSIONER GIRARD: On page 28 under paragraph 1 "Factors influencing development" and you have a number of factors and one is the lack of or availability of personnel. To what extent would this curtail your development of the service in the future?

MR. KING: Well, I might make a general



King

9741

comment on that. It is awfully difficult, of course,
to answer a question on that, because when it supplies
at a certain level you want then you make an effort
to double it. If the program is doubled personnel are
always found. I do not know but it is an acute problem
for hospitals and other institutions to find personnel.
As you know, we have about 340 nurses in Ontario and
we are training in public health 40 to 50 each year.
The national office is providing bursaries for students
and this past few years we have got 25 to 30 from the
national office. In addition to that the national
branch has branch bursaries and this brought in 20 to
25 students a year and it is a very good inducement for
nurses to take this post-graduate training because it
is a \$1,000.00 scholarship. If the others have something
to add to that?

-

-

-



1935

1935

comment on that. It is awfully difficult, of course,
to answer a question in that, because when it comes
to a certain level you want then you make an effort
to do it. If the program is doubled personnel are
always found. I do not know but it is an acute problem
for hospitals and other institutions to find personnel
as you know, we have about 300 nurses in Ontario and
we are looking for public health 40 to 50 each year.
The national office is providing personnel for students
and this past few years we have got up to 30 from the
national office. In addition to that the national
branch has branch nurses and this brought in 30 to
40 students a year and it is a very good indication for
nurses to take this post-graduate training because it
is a \$1,000.00 scholarship. If the others have something
to add to that.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30



Anderson 9742

C/ss

MR. ANDERSON: Well, Mr. Chairman,

if a rapid expansion were undertaken there would certainly be a lot of bursaries.

COMMISSIONER GIRARD: There would be a lot?

MR. ANDERSON: Sure, it is difficult to acquire bursary funds.

COMMISSIONER GIRARD: How many applicants do you have for male nurses, or do you have any?

MISS SEEDS: Mr. Chairman, since I have been with the Toronto branch I can recall that we have had two applications, quite some years ago. That was before.

COMMISSIONER GIRARD: Before you were ready to take them?

MISS SEEDS: Yes.

COMMISSIONER GIRARD: Have you an open mind on taking male applicants now?

MISS SEEDS: Very definitely. The Toronto branch is very interested in what has been undertaken by the Vancouver branch, and we are hoping in the not too distant future that the Toronto branch will be able to do something in this field also.

COMMISSIONER GIRARD: Do you think this would help reduce the scarcity of personnel or could they never come in in large enough numbers to help this or could you use them in large numbers? Would there be facilities for using large numbers of male nurses or will it always be a very small percentage?

MISS SEEDS: Well, I couldn't say the



in fact

It is really important to know whether there would

be any kind of a...

...of course, it is different

...

...it is different

...the primary...

...the primary...

...you have for male nurses, or do you have any?

...Miss Smith: Mr. Chairman, since I

have been with the hospital since I can hardly say we

have had two applications, quite some years ago. They

...

...Miss Smith: Before we have

...

...Miss Smith: Now you are

...in taking male applicants...

...Miss Smith: Very definitely. The

...is very interested in what has been...

...by the hospital board, and we are hoping in the

...that the hospital board...

...in this field...

...Miss Smith: Do you think it is

...the security of personnel on our side...

...is in large enough numbers to help this...

...see them in the hospital? Would there be

...large number of male nurses...

...is a very small percentage?

...Miss Smith: Well, I don't know...



Seeds 9743

percentage. I wouldn't think that it would be half your staff, for instance, that would be male nurses. I think that if the community thinking about the use of male nurses were to change then they could be used in increasing numbers if they were available.

COMMISSIONER GIRARD: Couldn't you help change the community thinking about male nurses? I understand that is what was done in British Columbia. They started having male nurses and then there was a demand. Couldn't you create a demand instead of waiting for the demand.

MISS SEEDS: Yes, Mr. Chairman, I think we are very interested in this and we could see a need, and the use of male nurses could be made in visiting nurse services, and I think we are very anxious to get them started in this program.

COMMISSIONER GIRARD: Just as you have used certified nursing assistants to a limited amount, but still you are using them and with benefit, I expect.

MISS SEEDS: Too, Mr. Chairman, I feel that with the employment of male nurses we would be able to increase the type of patients that we don't serve now, who could be served with the employment of male nurses.

MISS MADDAFORD: It is possible it would only be the larger branches that could make use of the male nurses.

COMMISSIONER GIRARD: Excuse me?

MISS MADDAFORD: I said it is possible it would only be the large branches that could make use of male nurses.



...I wouldn't think that it would be fair to
...for instance, that would be a good reason. I think
...that it was certainly thinking about the use of
...there were to change then they could be used in these
...national if they were available.

COMMISSIONER: ...
...help change the community thinking about this process?
I understand that he was once in England to look
...They started having more nurses and then there was a
...Gordon, Gordon's was a nurse, instead of having
...the country.

...we are very interested in this and we would see a need
...and the use of male nurses could be made in various
...services, and I think we are very anxious to get that
...started in the process.

COMMISSIONER: ...
...need certified nursing assistants to a limited amount,
...but still you are using them and with benefit, I expect.

MISS STINE: ...
...feel that with the employment of male nurses we would
...able to increase the type of patient care we do, because
...now, who could be served with the employment of male

...it is possible
...the larger hospitals that are in the city
...the male nurses.

COMMISSIONER: ...
...I said it is possible
...the fact that there are more male nurses
...in the country.



Maddaford 9744

COMMISSIONER GIRARD: That is right, but it isn't the large branches that are suffering from lack of personnel, or, if the large branches had enough personnel they could turn some of their personnel over to the smaller branches that need more. I think this is a cooperative effort. Then, in the same paragraph, factors influencing development, under G:

"Availability of supportive services so necessary to home care plans, for example, part-time housekeeping services, meals on wheels and physiotherapy services."

How prevalent is this meals on wheels service or is it just in the thinking stage?

MISS MADDAFORD: Just in the thinking stage.

COMMISSIONER GIRARD: There is no service?

MISS MADDAFORD: It is a need we see in some communities.

COMMISSIONER GIRARD: It is a need you see in some communities, but it hasn't been developed yet. Couldn't the V.O.N. make a pilot project on that, experiment with it? I have heard it mentioned a number of times as being something desirable.

MR. KING: Mr. Chairman, many of these supportive and pilot projects would be more easily undertaken in an expanding type rather than a contracting situation. The attention of the Order is so far directed now to holding on to what is held today and in reaching the needs that are present without going further afield,



King 9745

while we have considered so many of these things they certainly haven't had the active consideration that would be given under different circumstances.

COMMISSIONER GIRARD: Would it be possible to get money for pilot projects of this sort? I don't know. I was throwing out the idea, because you see the need, and I think no one is in a better position to undertake this project, if they give you the money, because you have done so much.

MR. KING: Miss Seeds might say something on that.

MISS SEEDS: I know in the Metropolitan area in Toronto there is very active consideration going to a meals on wheels situation. There are several groups that are. I don't know how far along they are, but they have expressed an interest in doing something in this.

COMMISSIONER GIRARD: I say this because the V.O.N. is a pioneer in many other fields and very successfully so. If you tried maybe you could make a success of this. On Page 29, under Paragraph 4: Development of comprehensive medical care plans to include visiting nursing. This is again under the factors influencing development. To your knowledge has any medical plan approached the V.O.N. to study the inclusion of nursing in any pilot plans?

MR. KING: No.

COMMISSIONER GIRARD: I know in the medical care plans we have had briefs from so far none of them have mentioned nursing, but since you mentioned it here, I was wondering if there had been. I think some-



which we have considered so many of these things that
 certainly haven't had the active consideration as a
 the given under different circumstances.

COMMISSIONER SIMON: Well, it is no
 , decide to get money for pilot projects of this sort.
 I don't know. I was thinking out the idea, because you
 are the head, and I think no one is in a better position
 to undertake this project, if they give you the money,
 because you have done so much.

MR. SIMON: Miss Lewis might say some-
 thing or that.

MISS LEWIS: I know in the Metropolitan
 area in Toronto there is very active consideration going
 to a needs or needs situation. There are several groups
 that are. I don't know how far along they are, but they
 have expressed an interest in doing something in this.

COMMISSIONER SIMON: I say this
 because the V.C.N. is a pioneer in many other fields and
 very successfully so. If you tried maybe you could make
 a success of this. On page 2, under Paragraph #1:
 development of comprehensive medical care plans to include
 visiting nursing. This is again another one
 field of development. To your knowledge has any
 local plan approached the V.C.N. to study the feasibility
 of working in any pilot plan?

MR. SIMON: No.
 COMMISSIONER SIMON: I know in the
 region, care plans we have had chiefs from so far back
 of them have worked in this, but since you mentioned
 it, I was wondering if there had been a study.



King 9746

one told me some time ago some organization had been approached, it had been discussed, but nothing had come out of it. Can you see this as an expansion or an extension of your services?

MR. KING: Could we see it?

COMMISSIONER GIRARD: As for some insurance commercial companies.

MR. KING: It is possible.

MISS MADDAFORD: We did it before with the Metropolitan Life Insurance Company.

COMMISSIONER GIRARD: I know very well. That is what I mean. Why couldn't this be done with medical care plans?

MR. KING: It could be, sure.

COMMISSIONER GIRARD: They, at least, I hope, would pay the full cost of the visit as the Metropolitan used to pay.

MR. KING: We consider that it could be, this is something that could be done.

COMMISSIONER GIRARD: I see you are thinking about it because it was in your brief. I don't think, Mr. Chairman, I have any more questions except on Page 30 there is a paragraph on the amalgamation of branches. I agree with everything that is said on this page. I think it is a very good thing, the amalgamation of all branches. You can serve more people. You can do more with the same amount of people. You can get better in-service education. You can do a lot of things better with amalgamation. I haven't any questions on it. I agree with it. Thank you very much.

1914

one told me some time ago that the situation was
apparently, it had been there for a long time, but
out of it. Can it be that it is an extension of the
extension of your...?

MR. FINE: I don't know.

COMMISSIONER: I don't know.

...the... of the...

MR. FINE: I don't know. I don't know if it is
the Metropolitan Life Insurance Company.

COMMISSIONER: I don't know. I don't know if it is
that is what I mean. Why couldn't it be that the
... of the...

I hope, would not the full cost of the visit as the
... of the...

MR. FINE: I don't know. I don't know if it could
be, this is something that could be done.

COMMISSIONER: I don't know. I don't know if it is
... about it because it was in your mind. I don't
... Mr. Chairman, I don't know some questions about the
... of the... in a program on the subject of it.
... I agree with everything that is said on this
... I think it is a very good thing, the ... on
... of it. I don't know. I don't know if it is
... the same sort of thing. I don't know
... in-service education. I don't know if it is
... with ... I haven't ... of it.
I agree with it. I don't know.



King 9747

COMMISSIONER FIRESTONE: Mr. King,
on Page 10, Paragraph 36, you say the lack of understanding and knowledge of the services available to the citizens in the community has an effect on the use and demand for the service. Then you conclude the paragraph by saying, and I quote:

"It is believed that many patients who need the service never get it".

My question, sir, is what can be done about that.

MR. KING: Will you answer that, Miss Maddaford?

MISS MADDAFORD: I would think, sir, that we need to probably do more in the interpretation of services, and I think that our hospital liaison programs are helping to do this, because it does make an informal meeting-place for the nurses with the doctors and so often they find --- just the other day one of the nurses mentioned that it wasn't only the hospital patients that she felt the program was benefiting, because even while she was in the hospital, she met a doctor in the ward and he said there is Mr. So and So out in the community who could very well use your services. Therefore, this helps bring in more patients to us, not only from the hospital, but from the community and I think we really have to keep our services before the doctors.

COMMISSIONER FIRESTONE: How are you doing it? Are you doing anything actively or leaving it to chance?

MISS MADDAFORD: We also use the various



100

on page 11, paragraph 12, and on page 12, paragraph 13. The purpose of the services available to the citizens of the community has an effect on the way they demand for the services. When you consider the paragraph on page 11, paragraph 12, and on page 12, paragraph 13, it is believed that many people who need the service are not getting it.

It is believed that many people who need the service are not getting it. The reason for this is that the service is not being provided in a timely manner. The service is being provided in a way that is not efficient and is not meeting the needs of the community.

It is believed that many people who need the service are not getting it. The reason for this is that the service is not being provided in a timely manner. The service is being provided in a way that is not efficient and is not meeting the needs of the community.

It is believed that many people who need the service are not getting it. The reason for this is that the service is not being provided in a timely manner. The service is being provided in a way that is not efficient and is not meeting the needs of the community.

It is believed that many people who need the service are not getting it. The reason for this is that the service is not being provided in a timely manner. The service is being provided in a way that is not efficient and is not meeting the needs of the community.

It is believed that many people who need the service are not getting it. The reason for this is that the service is not being provided in a timely manner. The service is being provided in a way that is not efficient and is not meeting the needs of the community.

It is believed that many people who need the service are not getting it. The reason for this is that the service is not being provided in a timely manner. The service is being provided in a way that is not efficient and is not meeting the needs of the community.

It is believed that many people who need the service are not getting it. The reason for this is that the service is not being provided in a timely manner. The service is being provided in a way that is not efficient and is not meeting the needs of the community.



Maddaford 9748

media, the press, the radio and television. I think Mr. Johnston has something to add here.

MR. JOHNSTON: There are also bulletins sent out from the various branches to doctors in the area and nurses also call on doctors to introduce the service program. They do their very best to keep this before the public.

MR. KING: Also in the smaller districts, particularly, not so much in Toronto, in the smaller areas there is some use made of the local press.

COMMISSIONER FIRESTONE: Well, when patients leave the hospital, are they advised if they get into difficulties or a crisis they can get some help from the V.O.N. nurses?

MISS MADDAFORD: In some of the branches it is rather interesting that they place cards on the bedside table to let patients know that this service is available. Also we try to keep contact with personnel in the hospital. Some times the nurses meet with the hospital nurses through their staff education program to interpret the V.O.N. services, and also the nurses do a fair amount of talking to groups. We have also made use of the Medical Society by addressing the Medical Society at the regular meetings, and on occasion we have used the Medical Advisory Committee to help interpret the services to the doctors at their staff meetings.

COMMISSIONER FIRESTONE: Are you not in a dilemma, on the one hand you would like to see your service used increasing but as the services are used



King 9749

increasingly your financial difficulties are getting worse.

MR. KING: That is right.

COMMISSIONER FIRESTONE: What is the solution, do you want to cut back your services, or do you want more money?

MR. KING: We want to enlarge. As far as Ontario is concerned, we want to enlarge our services. The whole objective of the Order is to help people in need and while we are governed by the amount of money we have to pay for the service we try to give the service first and then look for the money.

COMMISSIONER FIRESTONE: That leads me to your concluding Paragraph 105 on Page 31. You say the Victorian Order of Nurses in Ontario is prepared to cooperate fully in any health plan that may be set up so that the citizens living in the Province may be assured of visiting nurses. Let us assume that such a comprehensive medical care plan is introduced and adequate financing arrangements are made, would you expect that the demand of the services of the V.O.N. nurses would be substantially increased?

MR. KING: We do, yes.

COMMISSIONER FIRESTONE: Would you have the bodies to meet this demand?

MR. KING: At the moment we just have the present staff to meet the present need. We would be in the problem, of course, of finding additional staff.

COMMISSIONER FIRESTONE: In other words, you would expect a significant increase of demand.



King 9750

It may take you several years until you are able to meet the demand. Is that the situation you are facing?

MR.KING: Well, I think the question of staff, of course, is a general one. The staff at the moment, the nursing staff, as the Commission probably well knows, are fully occupied now. If there is going to be an enormous increase in the demand for nurses there has either got to be a redistribution of existing staff, if you are going to do more nursing in the home and out of the hospital then, obviously, nurses are going to be released. If that doesn't occur, then obviously there is going to be a shortage of nurses and then we will have to encourage those interested in the program to the Order or to the nursing profession.

COMMISSIONER FIRESTONE: This is a very reasonable suggestion, sir, what I am trying to visualize is the timing of such a program. What do you do first? Do you train the nurses you have got when the medical care plan is put into operation or do you put the plan into operation first and then you struggle along? How do you go about it?

MR. KING: If I may put in a personal opinion, you put the plan into operation first. If you wait until you get the staff you may never have the staff or the plan.

COMMISSIONER FIRESTONE: That is a very constructive reply. Thank you very much.



R/hm

9751

1
2
3
4 COMMISSIONER STRACHAN: Mr. Chairman,
5 I am surprised that this question has not been asked
6 already. Referring to, as you state in paragraph 105
7 "any health plan" and again your number 14 of the
8 recommendations, the "overall plan of health care".
9 How do you foresee the community appeal being affected
10 in such circumstance?

11 MR. KING: Do I understand the question
12 to be that if there is a plan produced how will this
13 affect the participation of the community appeal in it?

14 COMMISSIONER STRACHAN: Yes.

15 MR. KING: Well of course we can only
16 surmise as to how it will affect it. I suspect the
17 community appeal will consider that its funds available
18 should be spent for other purposes. They have already
19 suggested that to us.

20 COMMISSIONER STRACHAN: You do not
21 think it would be up to the 47%?

22 MR. KING: No. There has been increasing
23 comment raised by United Appeals in various parts of
24 the Province, particularly here in Toronto, and we have
25 been under increased questioning when the budgets are
26 passed as to what efforts we have made to acquire
27 funds from other sources, and should we not put increasing
28 pressure to bear on other sources. They are very much
29 conscious of this problem.

30 COMMISSIONER BALTZAN: You are very
experienced people in relation to one or two things I
have in mind, and that is on page 53, the last three
or four lines and it has to do with financial need as



King

9752

1
2
3
4 determined by a means test involving a comparison of
5 the applicant's income and liquid assets with his
6 monthly living expenses. My first question is: Do
7 you find that people in need feel humiliated by going
8 through this process of enquiry?

9 MR. KING: May I let Miss Maddaford
10 answer that since she has been directly connected with
11 it.

12 COMMISSIONER BALTZAN: This is no
13 reflection on anybody. I want to explain this has been
14 a recurring question. We have had lots of answers and
15 we would like to know just what your experience is.

16 MISS MADDAFORD: I think with some
17 people it is very humiliating. This Act is a little
18 broader. There are many people qualified to apply for
19 this service that are top line cases that have never had
20 welfare; and first of all in approaching the patient
21 regarding the legislation, we arrange our own fee. We
22 sort of go into our process of arranging the fee first.

23 Then, if the patient is not able to
24 pay the full fee, or part of the fee, then we introduce
25 the Homemakers and Nurses Service Act in the areas where
26 it has been implemented and if the families have some
27 feeling that they do not want to -- we explain the means
28 test, and if the families do not feel that they want
29 to be subjected to this means test, then we do not force
30 them to go through with it.

THE CHAIRMAN: But you continue to give
the service?

MISS MADDAFORD: We would continue to



Maddaford

9753

1
2
3
4 give the service, yes sir.

5 COMMISSIONER BALTZAN: In other words,
6 you respect the tender feeling on the part of people.
7 On the whole, would you say that there is any overt
8 resentment to having to answer your questions? Is there
9 an overall resentment. Is that something you have to
10 contend with?

11 MISS MADDAFORD: No. I think most
12 people feel that if it is going to help the Victorian
13 Order that they are quite pleased to go along with the
14 means test and I think with proper interpretation they
15 accept it quite well.

16 COMMISSIONER BALTZAN: In other words,
17 they are very considerate?

18 MISS MADDAFORD: Yes, they are.

19 MR. KING: The evidence that has come
20 to me on that is while there is no overwhelming resentment
21 about it, there is some objection to it, in varying
22 degrees, and some cases they are suprised, of course
23 that the V.O.N. would ask them to do this, knowing of
24 the V.O.N.'s past service.

25 COMMISSIONER BALTZAN: Lastly, who
26 makes this assessment? The visiting nurse? The welfare
27 worker or some official?

28 MISS MADDAFORD: In most cases it is
29 the welfare officer. In some of our smaller branches
30 where they have no welfare officer, as such, they ask
the Victorian Order to do it. I can't speak for the
Toronto branch.

MISS SEEDS: Welfare officers do it all



Seeds

9754

1
2
3 in the Metropolitan area.

4 COMMISSIONER STRACHAN: What per cent
5 of your patients pay the full fee, or can pay?

6 MR. KING: I don't know whether we
7 have that or not. It is quite small. Only 18%, of
8 course, of the entire income of the Order comes from
9 patients' fees. Do we have that worked out? I don't
10 think we have the figure available.

11 COMMISSIONER STRACHAN: It is low?

12 MR. KING: It is low. Quite low, yes.

13 THE CHAIRMAN: Thank you very much
14 Mr. King and your associates. We will proceed now with
15 the National submission and I assume you are going to
16 perhaps remain and if there is anything that arises
during that, there may be further comment.

17 THE SECRETARY: I would like to call
18 Mr. Jeffery to present the Victorian Order of Nurses brief
19 for Canada and present the people who will accompany
20 him. The submission will be known as exhibit number 266.

21 ---EXHIBIT NO. 266:

Submission by the
Victorian Order of
Nurses for Canada.

22
23
24
25
26
27
28
29
30



in the form of a letter.

I would suggest a very simple form, say, on one side, a
"To Whom It May Concern" and on the other side, a

space for the name of the person to whom it is addressed.
I think it is quite simple. I think it is quite simple.
I think it is quite simple. I think it is quite simple.
I think it is quite simple. I think it is quite simple.

MY NAME: It is John. I think it is John. I think it is John.

The name of the person to whom it is addressed.
I think it is quite simple. I think it is quite simple.
I think it is quite simple. I think it is quite simple.
I think it is quite simple. I think it is quite simple.
I think it is quite simple. I think it is quite simple.

I think it is quite simple. I think it is quite simple.
I think it is quite simple. I think it is quite simple.
I think it is quite simple. I think it is quite simple.
I think it is quite simple. I think it is quite simple.

I think it is quite simple. I think it is quite simple.
I think it is quite simple. I think it is quite simple.



SUBMISSION OF
VICTORIAN ORDER OF NURSES FOR CANADA

APPEARANCES: Mr. J. Jeffery
Mr. S. Thom
Miss J. Leask
Miss C. MacArthur

MR. JEFFERY: Mr. Chairman, it is my privilege to present the brief of the Victorian Order of Nurses for Canada. Before doing so, may I introduce my associates. On my left is Mr. Stewart Thom, Chairman of the Board of Management. On my immediate right is Miss Jean Leask, our director in chief and next to her is Miss Christine MacArthur, our education director. If it so pleases you, I would wish to present our brief to you.

The Victorian Order of Nurses for Canada wishes to express its appreciation to the Royal Commission on Health Services for the opportunities it has had to present statements in each province on the services being provided by the branches. It is also grateful for this further opportunity of presenting its views on the provision of visiting nursing service in Canada.

At the first hearing of the Royal Commission on Health Services held in Halifax, October 31st, 1961, the Victorian Order of Nurses for Canada presented a Preliminary Statement outlining the development of the Order, its overall objectives, structure and administration, as well as the general policies under which service is given in all branches. A copy of the



summary of the Preliminary Statement, including the stated objectives of the Order is found in Appendix I.

At the request of the Commissioners a statement has been included regarding the role of the Victorian Order of Nurses as a voluntary organization and its future in a comprehensive health plan.

It is our hope that this brief will be of value to you in your study of the health needs of Canadians.

1. The views herein expressed by the Victorian Order of Nurses for Canada are based on its experience in providing a visiting nursing service in communities of varying sizes for over 60 years. In presenting these views it is recognized that, in addition to the services the Victorian Order provides in Canada, visiting nursing care is also provided in some communities by other voluntary organizations and by departments of health. Nothing that may be said in any of its submissions should be regarded as indicating any lack of appreciation of these services or a desire to supplant them.

2. With the founding of the Victorian Order, visiting nursing was introduced in Canada and since that time the provision of this services has been its primary function. Through the years the Order has given leadership in the growth and development of this service and in setting and maintaining standards which influence the quality of care. Visiting nursing is acknowledged as one of the foundations on which public health nursing is built. Recognizing its concern, not only with the care of the sick, but also with the prevention



Jeffery

9757

1
2
3
4 of illness and the promotion of health, the Order has
5 contributed to the establishment and development
6 of other public health nursing services in many
7 communities across Canada.

8 3. The service given by a Victorian Order
9 nurse is centred not only on the individual as a member
10 of a family in a community, - "an individual whose illness
11 and health, mental, physical and emotional, will be
12 influenced by and will influence the health and illness
13 of other members of that family and that community".
14 In every visit the teaching function of the nurse is
15 considered equally as important as the bedside care.
16 In providing this skilled nursing care on a part-time
17 or visit basis, each nurse can care for a member of
18 patients in any one day.

19 4. In any plan for home care, visiting
20 nursing service is a most important factor. Based
21 on its experience in the administration and provision
22 of visiting nursing service, the Order emphasizes the
23 following essential features:

- 24 (a) the service should be available to all
25 who need it;
26 (b) the need of the patient should determine
27 the amount of service given;
28 (c) the service should be available 24
29 hours a day - 7 days a week;
30 (d) the patient should be under the medical
supervision of a qualified physician;
(e) the service should be provided,
administered and supervised by nursing personnel.

of illness and the protection of health, the Order has
contributed to the establishment and development
of other public health nursing services in many
communities across Canada.

The service given by a Visiting Nurse
is not confined to the individual as a member
of a family in a community, - "an individual whose illness
and health, mental, physical and emotional, will be
influenced by and will influence the health and illness
of other members of that family and that community".
In every visit the teaching function of the nurse is
considered as important as the bedside care,
in providing the skilled nursing care on a part-time
or full-time basis, each nurse has given to a member of
patients in any one day.

In any plan for home care, visiting
nurse service is a most important factor
in the expansion in the administration and provision
of visiting nursing services, the Order emphasizes the
following essential features:

- (1) the service should be available to all
- (2) the service should be available to all
- (3) the service should be available to all
- (4) the service should be available to all
- (5) the service should be available to all
- (6) the service should be available to all
- (7) the service should be available to all
- (8) the service should be available to all
- (9) the service should be available to all
- (10) the service should be available to all



1
2
3
4 IT IS RECOMMENDED THAT in any future health care program
5 provision be made for visiting nursing service,

6 THAT the essential features of a
7 visiting program be maintained, and

8 THAT nursing personnel be included at
9 all levels of planning in such programs.

10 5. Although Victorian Order service is
11 available to 51% of the population in nine province,
12 there are many areas in Canada where a visiting nursing
13 service would be of great benefit in maintaining and
14 promoting the well-being of the citizens. Up to the
15 present time branches have been organized when there
16 was interest in an area, a survey revealed the need for
17 such a service, and the community was willing to give
18 support financially. The Victorian Order is willing
19 to review its present method of extending its service
20 and to discuss possibilities for the financing of such
21 extension with all who may be interested.

22
23 IT IS RECOMMENDED THAT consideration be given to ways
24 and means of initiating visiting nursing service in areas
25 where it is not available.
26
27
28
29
30



Jeffery

9759

6. As noted in all provincial submissions there has been a decided increase in service to persons with long-term illnesses and to those in the older age group. When an older person becomes ill, the illness tends to be of a chronic nature. These people usually prefer their own home to an institution and make a better recovery there. (Paragraphs 40 - 48)

IT IS RECOMMENDED THAT in any health care scheme, consideration be given to the care of the increasing proportion of the population in the older age group in their own homes.

7. Following World War II when interest in rehabilitation nursing first began, the Victorian Order recognized that in this way many long-term patients could be assisted to a more useful life and began incorporating rehabilitation techniques in all nursing care. Since that time the Order has taken a leading part in interpreting the role of nursing in rehabilitation programs. Through in-service programs, and institutes across Canada this concept has been brought not only to Victorian Order staff but to nurses from hospitals and other agencies. Since it is expected that more and more long-term patients will be cared for at home, the Victorian Order will continue to play an important part in rehabilitation programs. Up to this time it has assumed complete financial responsibility for the preparation of staff, and has given bursary assistance to a number of nurses to secure special preparation in this field. It is considered that medical rehabilitation



Jeffery

9760

grants should be available to the Order to promote the training of consultants in rehabilitation nursing.

(Paragraphs 40 - 48, 73 - 75)

8. To ensure continuity of nursing care for patients being discharged from hospital, referral programs have been established in 36 branches. These programs are of benefit not only to the patient but to the hospital, since many patients may be discharged earlier and the likelihood of their need for readmission is reduced. (Paragraphs 49 - 52, 65 - 68)

IT IS RECOMMENDED THAT referral programs be initiated in all hospitals and that provision be made in hospital budgets for payment of all costs.

9. The co-ordination of existing community resources through an organized home care program leads to more effective use of community facilities and makes it possible to give adequate care at home to selected patients who would otherwise need to be hospitalized. Such programs would not only contribute to the welfare of the patient but would relieve the present strain on already strained hospital facilities. (Paragraphs 53 - 59, 69 - 72)

IT IS RECOMMENDED THAT in any health care program there should be provision for the financing of organized home care programs, and THAT these programs be set up under auspices which will provide this care for any patient whether he requires a period of hospitalization or can be



Jeffery

9761

cared for entirely at home.

10. Although nursing is considered an essential in caring for patients at home, other services also require development. (Paragraphs 88 - 92) One of the most urgent is housekeeping services. (Paragraphs 79 - 82)

IT IS RECOMMENDED THAT consideration be given to the provision of housekeeping service on an hourly or daily basis according to need and regardless of a patient's ability to pay.

11. With the new concept of rehabilitation, new types of equipment are required to assist patients in living more independently. The cost of some of the items is often prohibitive to the patient. (Paragraphs 83 - 86)

IT IS RECOMMENDED THAT resources for providing rehabilitation equipment for use in the home be developed.

12. Many older citizens living in rooms with limited facilities are not able to prepare adequate meals. Since poor food habits often predispose to ill health it is suggested that consideration be given to the establishment of a 'meals on wheels' service or some other method of providing adequate meals, to meet this increasing problem. (Paragraph 87)

13. At the present time 22 branches provide a part-time occupational health nursing service for small industries. Because the provision of nursing care in the home is the first concern of the Victorian



Jeffery

9762

Order this service has not been developed to the extent that it might be. It is felt that this is a field in which the Order could make a substantial contribution to the health and welfare of the wage earners if adequate public health nursing staff and finances were available to allow for expansion of programs. (Paragraphs 76 - 78)

14. The Victorian Order functions primarily in the field of visiting nursing. Other services are undertaken however, to fill a need for service which is not offered by another agency or to contribute to a more comprehensive service in a community through sharing a program with another agency. The role of the voluntary agency is to explore and demonstrate new programs and to supplement and complement the work of official agencies. In line with this, special projects could be undertaken by the Victorian Order in developing new areas of service and in testing new methods of organizing and financing visiting nursing service. Such projects might be financed through special grants. (Paragraphs 57, 93 - 100, 133, 134)

15. Since its inception the Victorian Order has been financed through three main sources - fees from patients, government grants and voluntary contributions. The amount from each source varies in each province depending on the services being provided. It is expected that the Victorian Order will continue to be dependent to a great extent on voluntary giving to maintain its services. In 1960 48% of the receipts of its branches and 78% of the funds available for the national office were from this source. At the same time,



Jeffery

9763

only essential services have been possible and there has been little opportunity for expansion. (Paragraphs 101 - 105, 113 - 124)

16. As noted in the provincial submissions, since national hospital insurance became effective, there appears to be a growing resistance to paying for nursing care at home when it can be obtained in hospital through the insurance plan. If home care could be included as an extension of hospital service under the present hospital insurance program, there would be a better utilization of facilities for care. (Paragraphs 126, 131, 132).

IT IS RECOMMENDED THAT consideration be given to prepayment for visiting nursing service based on the same principle as the present hospital insurance programs.

17. Although Victorian Order service is available to all regardless of ability to pay, there is a charge based on the cost which is computed annually by each branch. Those who are able, pay this charge. Those who can only pay a small part of the fee, or none at all, are usually indigent or medically indigent. The Victorian Order believes that health or welfare departments (as in Saskatchewan, Manitoba, Newfoundland, and to a limited extent in Ontario) should assume responsibility for payment of the cost of nursing service given to these indigent patients. The estimated cost of a visit has been used as the basis for contractual arrangements with provincial governments, the Department of Veterans' Affairs, insurance companies, industrial



Jeffery

9764

firms and others. The Victorian Order has therefore had long experience in providing service on a contractual basis. If this type of arrangement were extended it could be one way of financing the service in a more adequate manner. (Paragraphs 125 - 130)

18. The quality of care which can be provided by the Victorian Order in present programs and in any future development is influenced by the availability of qualified personnel, for staff, supervisory, consultant or administrative positions. As a voluntary agency, the funds available for bursary assistance are limited and have been found inadequate to prepare the number of personnel necessary for expansion of present programs or development of new programs. (Paragraphs 136 - 161)

IT IS RECOMMENDED THAT in any proposal for the training of personnel, the needs of the Victorian Order be considered.

19. Since the national office has successfully co-ordinated at both board and staff levels, over 100 local branches in nine different provinces into one organization with common objectives, standards and goals, it is firmly believed that the national aspect of the Order has been a strength and should be maintained. (Paragraphs 18 - 31)

20. Through the years as a voluntary agency, the Victorian Order has repeatedly demonstrated its flexibility by providing a variety of services in communities across Canada and adapting its program to the changing needs of a community and the progressive development of other health services. It reaffirms its



...and ...
...had long experience in providing services of a ...
...it was ... were extended in
...of a ... in a ...
... (Paragraphs 125 - 127)

16. The ... of ... can be
... by the ... in present ... and
... is ... by the availability
of ... for staff, ... ,
... . As a voluntary ... , the
... are limited and
... have been found ... the ... of
... expansion of ...
... (Paragraphs 128 - 131)
IT IS REQUESTED THAT in any proposal for the training
of personnel, the needs of the ...
... be considered,

17. Since the ... has
... at both ... levels,
... in ...
... with ... ,
... it is ...
... and should be maintained.
(Paragraphs 132 - 134)

18. ... as a voluntary
... has ...
... a variety of ... in
... and ...
... of a ...
... in ...



Jeffery

9765

belief in the role of the voluntary agency as a pioneer in the provision of health services and is willing to participate in the planning or implementation of programs which would bring about better health care for the people of Canada. (Paragraphs 9, k0, 166, 167)

21. The Victorian Order of Nurses for Canada believes that many more patients can be cared for at home than is the case at present if necessary services are made available, and therefore in conclusion:

IT IS RECOMMENDED THAT the provision of services for care in the home be included in any future planning for health care in Canada.

Most respectfully submitted, Mr.

Chairman.

THE CHAIRMAN: Thank you very much, Mr. Jeffery.

COMMISSIONER VAN WART: Turning to page vii, your Recommendation No. 16:

"That consideration be given to prepayment for visiting nursing service based on the same principle as the present hospital insurance programs."

Under such a scheme, would you still continue as a voluntary organization?

MR. JEFFERY: Well, we would certainly hope to do so, Mr. Chairman. We thought of that when we made the submission, and we hope the net result of that would be that we continue as a voluntary organization.

COMMISSIONER VAN WART: In other words,



Jeffery

19766

the scheme would use your home nursing service as a wing of the scheme, you operating on a voluntary basis. Is that what you had in mind?

MR. JEFFERY: That was our suggestion. I'd better just check with my chief here.

MISS LEASK: I would say that this was the thought, that service could, you might say, be bought in this way from an existing organization.

THE CHAIRMAN: A voluntary organization and giving the service and make it available?

MISS LEASK: Yes. This would be an arrangement to use our organization to provide the service.

COMMISSIONER VAN WART: That would mean financially your finances would come from the scheme almost entirely, would it not? You were saying that your other sources might dry up if you went in under the scheme.

MR. JEFFERY: Well, the point, Mr. Chairman, is this: that we frankly are struggling along now with about the maximum load that we can take on with the finances available. There are many things we would like to do and we think should do. We have many experimental schemes, which many of you have seen in the papers or know personally, which we think indicate the way the benefits could go, if we only had a very modest additional increase, in co-operation with the various authorities.

COMMISSIONER VAN WART: You make the same statement in this brief that we have heard in other



10. 1947

10. 1947

The same would be your own private service as a volunteer, and the same, with the exception of a voluntary service, is that you had in mind.

Yes, indeed, that was our suggestion.

And the first check with the other hand.

The second, I would say that this was

the first, that we were doing, you know, as

soon as this was done in the organization.

Yes, indeed. A voluntary organization

and giving the service and also it was

the first. Yes. This was the

arrangement to be made, the first to be made

the first.

Yes, indeed, the first, the first

the first, the first, the first, the first

the first, the first, the first, the first

the first, the first, the first, the first

the first.

Yes, indeed, the first, the first

the first, the first, the first, the first

the first, the first, the first, the first

the first, the first, the first, the first

the first, the first, the first, the first

the first, the first, the first, the first

the first, the first, the first, the first

the first, the first, the first, the first

the first, the first, the first, the first

the first, the first, the first, the first

the first, the first, the first, the first

the first, the first, the first, the first



Jeffery

9767

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

briefs, that since the hospital service plans have come in, the collection of fees from patients going home from the hospital was not as much, they think they should have stayed in the hospital, and if a scheme comes in you would think the private remuneration would dry up.

MR. JEFFERY: Well, of course, we can't guess. That is not an unlikely assumption.

COMMISSIONER VAN WART: I was just thinking where the monies would come from. You would have to depend upon plans which would buy your services for a certain rate as a voluntary organization. That is what you had in mind?

MISS LEASK: I think this would stabilize the financing for your basic visiting nursing service. Perhaps I am wrong, but I would think that other funds, perhaps voluntary funds or foundation funds, would be available for experimental programs or for other types of programs, but at the present time we are using all our funds to provide this type of service, whereas if the financing were stabilized for the provision of this basic care, then I think we could probably find other funds or these funds that are now going into this service might be available to us to do experimental type of work.

MR. JEFFERY: We have many friends - perhaps not as many as we would like - who do contribute to us from time to time by bequests and so forth which would allow us to do these extra things which we think would be available, which might not be available under



January

...that since the last I saw you, I have been
in, the collection of books from that date, and
from the hospital was not a word, then this day
should have been a day of trial, and it is a trial
because if you would think the hospital, it would be a trial
any day.

...well, of course, we can't
guess. That is not my very assumption.

...I was just
thinking about the money which came from you. You would
have to depend upon that which would pay your expenses
for a while, and a very long organization. The
is what we are doing.

...I think this would
stabilize the situation for your basic visiting and
...I would like to
other than, and I would like to have a
would be available for the most part of the
...the same time as the other time to the
all our time is spent in a type of service, and
if the time were stabilized, the situation of
this basic case, then I think we could possibly
other than those who are in the group into the
service which we will have to be in a different type

...I think we should
...and we would like to have a
...by depositing the money in
...to the hospital.



Jeffery

9768

the proposal you put forward theoretically.

COMMISSIONER VAN WART: The theoretical proposal would have a tendency for people not to donate as generously as previously?

MR. JEFFERY: That is a hard thing to say. It is marvellous the reactions to our blue girls going into the home. And this service is given to a pauper or a millionaire. It doesn't matter to us; if the need is there we give it.

COMMISSIONER VAN WART: That is your voluntary appeal, voluntary organization.

MR. JEFFERY: It is surprising how some wealthy person requests us for bursaries or some additional provision.

COMMISSIONER FIRESTONE: Mr. Chairman, I would like to welcome Mr. Jeffery, President of V.O.N. I know how helpful he is in dealing with questions.

My first question relates to the second last paragraph in your introductory statement where you speak of the Victorian Order of Nurses playing its part in the future in a comprehensive health plan. I understand from the discussion that has taken place today, so far, and some comments from the Ontario Association of the V.O.N., presumably it is along similar lines, that your group would be providing a service and it would be paid for that service out of funds collected under a comprehensive health care plan?

MR. JEFFERY: In part, except for these extra donations we would hope to receive.

COMMISSIONER FIRESTONE: But the health



Jeffery

9769

care plan would pay for the service you offer to people for home care?

MR. JEFFERY: Yes. But may I explain so that there may be no misunderstanding. As an economist, you will be aware of the situation. The cost is not only of the nurses, there are other costs which have to be added to arrive at it.

COMMISSIONER FIRESTONE: So the answer is the total cost of providing this particular service?

MR. JEFFERY: Yes, that is right.

COMMISSIONER FIRESTONE: How would that payment be made? Would it be made at so much a visit, or have you some other method in mind?

MR. JEFFERY: We think the cost per visit has gone down, in effect.

MISS LEASK: Mr. Chairman, this is our present method of computing our cost, on a per visit basis. There is another method and this is used to a certain extent in large branches in the United States, on a time basis. But our method adopted in Canada is on a per visit basis, and that is our present method.

MR. JEFFERY: There is a third method, but I don't know how we would do it. A per capita basis, pay us so much on a per capita basis, and like the Chinese, we would have to keep them well, I guess.

COMMISSIONER FIRESTONE: I take it that the principle on which the whole health care plan may be based is this principle of prepayment, with the risk spread over the whole population. But if I understood you correctly, the suggestion would be that your Order



2-1-35

...and would pay for the service and other to people

for these cases.

MR. JEFFREY: Yes, but what I explain

is that there may be no minimums and that, as an economic

you will be aware of the situation. The cost is not only

of the houses, there are other costs which have to be

added to arrive at it.

COMMISSIONER FLETCHER: As the answer

is the total cost of providing this particular service?

MR. JEFFREY: Yes, that is right.

COMMISSIONER FLETCHER: Now would that

payment be made? Would it be made at so much a visit,

or have you some other method in mind?

MR. JEFFREY: We think the cost per

visit has gone down, in effect.

MISS LEAS: Mr. Chairman, this is our

present method of computing our cost, on a per visit

basis. There is another method and this is used to a

certain extent in large branches in the United States,

on a time basis. But our method adopted in Alaska is

on a per visit basis, and that is our present method.

MR. JEFFREY: There is a third method,

but I don't know how we would do it. A per capita basis,

pay us so much on a per capita basis, and like the

others, we would have to keep them well, I guess.

COMMISSIONER FLETCHER: I take it that

the principle on which the whole health care plan may be

based is this principle of payment, with the risk

spread over the whole population. But if I understand

you correctly, the suggestion would be that you



Leask

9770

would be paid on a per visit basis on an amount which you would assess for your actual cost plus an allowance for overhead?

MISS LEASK: The present cost of our service does include the overhead. When we say a visit in a branch costs so much, that is the entire cost, administrative, and the entire cost in that field.

COMMISSIONER FIRESTONE: I take it of the three methods that have been suggested, your recommendation is that it be on the basis of a visit in its totality?

MISS LEASK: We would agree with that. We would try another basis if it were suggested.

MR. THOM: There is another basis, and that is if the public authority, provincial, municipal or as you please, has decided that the Order is giving a service it will cover a deficit at any given period of time, and the tendency has been to remunerate the Victorian Order on a visit basis, on a contractual basis, if I may use that word.



M/hm 1

2

3

4

5

6

7

8

9

10

11

12

13

14

COMMISSIONER FIRESTONE: May we now turn to paragraph 5 on page III in which you comment on the fact that there are a number of areas where no V.O.N. services are available and you provide us with a recommendation which suggests ways and means that may be found of initiating visiting nursing services in such areas. Now, in reading over paragraph 5 I see you are giving mainly two reasons for the lack of services, one is lack of interest and two, inadequate financial support. Now, what can be done to overcome these two factors which are in the way of providing increased service in these areas now?

15

16

17

18

19

20

21

22

23

24

25

MR. JEFFERY: In studying this problem at all levels at the present time to see what can be done to improve the system we presently have that expansion which is not covering areas we would like to see it cover, we feel if we were not running on a shoe-string or so close to the limit of our resource that possibly by using trained personnel we might be able to get a great interest in these areas and maybe encourage them to pick up the torch and carry on with us. At the present time we have not got the staff to do it the way we would like to. The financial side, of course, is a very difficult one. I do not know what the answer to that is.

26

27

28

29

30

COMMISSIONER FIRESTONE: I think you have given us the answer, if your operating cost to enlarge service was taken care of by a plan you would be able to obtain additional funds to use for the development of additional services as well as research?



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

COMMISSIONER: Now, we have

turn to paragraph 2 on page 11 in which you mention
on the fact that there are a number of areas where no
V.O.M. services are available and you mention us with
a radio station which has a wave and means that we
found of initial in visiting service as in other
areas. Now, in reading over paragraph 5 I see you are
giving mainly two reasons for the lack of service,
one is lack of interest and two, inadequate financial
support. Now, what can be done to overcome these
two factors which are in the way of providing increased
service in these areas now?

MR. JEFFREY: In studying this problem

at all levels at the present time to see what can be
done to improve the system we presently have that
expansion which is not covering areas we would like to
see it cover, we feel it we were not running on a shoestring
a bit or so close to the limit of our resources that
possibly by using trained personnel we might be able
to get a great interest in these areas and maybe
encourage them to pick up the torch and carry on with
us. At the present time we have not been able to
do it the way we would like to. The financial side,
of course, is a very difficult one. I do not know
what the answer to that is.

COMMISSIONER: I think you

have given me the answer, if you operating out to
extensive services was the case of by a plan you would
be able to obtain additional funds to use for the
operation of additional services as well as pay staff.



Jeffery

9772

1
2
3
4 MR. JEFFERY: I am somewhat of a
5 novitiate in this order but I have made the repeated
6 statement, as a business man, that there was no problem
7 there that adequate money and adequate nursing staff
8 would not cure.

9 MISS LEASK: May I add to this question
10 of initiating service? On page 21, paragraph 63 we
11 have set forth one method that might be used to get
12 around the financial problem in the beginning and that
13 would be if money was made available to initiate a service
14 in a community so for a period of one year the V.O.N.
15 might establish a service in the opposite way we do now
16 and develop community interest and support in that
17 time. We have a number of areas where we have had
18 requests to go in and talk to the people or try to
19 develop a service and when it comes to a certain point
20 of financing, this is a point at which they cannot
21 continue to try to establish the service. However, if
22 money was made available to establish that service
23 within a year you might develop that community to the
24 extent they could carry it themselves. It is to actually
25 to get in and initiate that is the trouble and I think
26 we have said here we have had in the past few months
27 eight requests to go into communities. Now, out of
28 these eight we feel two may develop from that. We cannot
29 really say exactly but we feel that one is a certainty
30 now. Out of eight we have two that may develop. I
think it is finances.

We have stated the amount we feel it
is necessary to establish a one-nurse branch in a



1. The first thing I noticed when I

arrived in the city was that it was a very

different place from what I had heard of.

The people were very friendly and

the food was very good.

I had heard that the people were

very friendly and the food was

very good.

I had heard that the people were

very friendly and the food was

very good.

I had heard that the people were

very friendly and the food was

very good.

I had heard that the people were

very friendly and the food was

very good.

I had heard that the people were

very friendly and the food was

very good.

I had heard that the people were

very friendly and the food was

very good.

I had heard that the people were

very friendly and the food was

very good.

I had heard that the people were

very friendly and the food was

very good.

I had heard that the people were

very friendly and the food was

very good.



Jeffery

9773

community.

COMMISSIONER FIRESTONE: Those are constructive comments, thank you very much. May I now turn to paragraph 6 on page IV, Mr. Jeffery. The submission suggests that consideration be given to the care of the increasing proportion of the population in the older age group in their own homes. Has your association any specific proposals how this could be achieved?

MR. JEFFERY: Miss Leask will have to answer that.

MISS LEASK: Miss MacArthur will have some ideas on that.

MISS MacARTHUR: I think we are thinking of the older person who is much happier in her own home and responds much better to care and treatment. In many instances they have no one to look after them, they are alone in their home and they need other services besides nursing services such as household services and meals and if these services were available they could be looked after at home and respond to the treatment and become more independent and recover more normally in their own home rather than in institutions. I think in an institution these people particularly tend to become apathetic and they have not any interest in becoming well again, there is no incentive to become well. However, in their own home they do have interest which keep them alive and keep them going.

COMMISSIONER FIRESTONE: If I understand you correctly, and please correct me if I do not, your

1973



Jeffery

9774

1
2
3
4 suggestion is that the nursing services alone will not
5 be adequate, you really need a more integrated home
6 care program that will give more than nursing service?

7 MISS MacARTHUR: In many instances
8 you need more services for this group of people.

9 COMMISSIONER FIRESTONE: What would
10 those additional services be so that you can provide
11 a comprehensive home care service?

12 MISS MacARTHUR: I think it has been
13 demonstrated in some of the organized home care programs
14 in several centres. In Toronto there is one and all
15 these services are co-ordinated, housekeeping,
16 physiotherapy, speech-therapy, occupational therapy,
17 nursing services and medical services.

18 COMMISSIONER FIRESTONE: That is very
19 helpful. There are a good many services to be supplied
20 but who would supply this multitude of services? If
21 your group can only supply one or two types, another
22 group can supply another type of service, you may have
23 four or five organizations all converging on that poor
24 old man or lady. How would this work in practice?

25 THE CHAIRMAN: You might have a
26 convention.

27 MISS MacARTHUR: I think in Toronto
28 it has worked very well and I think the patients feel
29 the benefit of this group effort. On their part they
30 do not feel it is a lot of different people converging
on them, they get the benefit of the group from the
different organizations or agencies.

COMMISSIONER FIRESTONE: Would you then



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

...is that the nursing services alone will not
be adequate, you really need a more integrated
care program that will give more than nursing services
MISS MARY THUR: In many instances

you need more services for this group of people.
COMMISSIONER FIRST: That would
those additional services be so that you can provide
a comprehensive home care service

MISS MACKENZIE: I think it has been
demonstrated in some of the organized home care programs
in several centres. In Toronto there is one and all
these services are co-ordinated, housekeeping,
physiotherapy, speech-therapy, occupational therapy.

COMMISSIONER FIRST: That is very
helpful. There are a good many services to be applied
but who would apply this kind of services? If
your group can only supply one or two types, another
group can supply another type of service, you may have
four or five organizations all working on that group
and man on fact. How would this work in practice?
THE CHAIRMAN: You might have a

MISS MACKENZIE: I think in Toronto
it has worked very well and I think the patients feel
the benefit of this group effort. On their part they
do not feel it is a lot of different people coming in
on them, they feel the benefit of the group from the
different organizations or agencies.
COMMISSIONER FIRST: Would you like



Jeffery

9775

1
2
3
4 suggest there would be some co-ordination amongst the
5 agencies concerned?

6 MISS MacARTHUR: Yes.

7 COMMISSIONER FIRESTONE: Now, if
8 this patient, this elderly person needs drugs, would you
9 supply her with those drugs?

10 MISS MacARTHUR: At the present time
11 they have to supply them themselves, there is no
12 provision for additional drugs in any plan.

13 COMMISSIONER FIRESTONE: And under
14 the plan which you envisage where nursing will be part
15 of the comprehensive medical care plan, assuming the
16 drugs are covered in such a comprehensive health care
17 plan, someone will have to bring the drugs to the
18 patient using the prescription of a doctor. Who would
19 do that? Would the V.O.N. take this on?

20 MISS MacARTHUR: No, it would be up
21 to the drug store to deliver or a member of the family
22 or friend of the family to secure the necessary drug
23 or equipment.

24 COMMISSIONER FIRESTONE: There must
25 be a lot of lonely people who have not neighbours or
26 members of the family living with them. What is the
27 objection to a visiting nurse bringing drugs that have
28 been prescribed by a physician?

29 MISS MacARTHUR: I think on rare
30 occasions a visiting nurse has done it but it is a poor
use of visiting nursing time to transport drugs and
equipment to the homes. In some instances we have
auxiliaries and friendly visitors and this group would



MacArthur

9776

1
2
3
4 be able to do these odd chores like this.

5 COMMISSIONER McCUTCHEON: A small boy
6 on a bicycle can do it?

7 COMMISSIONER FIRESTONE: Let us assume
8 the old man in bed cannot go to a phone, sometimes that
9 is a problem. However, we will not go into any more
10 detail on that.

11 I am now turning to recommendations
12 contained in paragraph 9 on page V in which you suggest
13 that in any health care program there should be provision
14 for the financing of organized home care programs and
15 these programs to be set up under auspices which will
16 provide this care for any patient where he requires a
17 period of hospitalization or can be cared for entirely
18 at home. Can you elaborate what you association means
19 by the term "under auspices"?

20 MISS LEASK: I think at the present
21 time organized home care programs are sponsored or
22 under auspices of various groups; some are sponsored
23 by a hospital. The plan in Toronto is under the
24 Department of Public Health for the City of Toronto;
25 the ones in the west are under hospitals and the ones most
26 recently formed in Moose Jaw is under a medical society.
27 We are not saying which auspices is the correct auspices
28 for a home care plan to be organized. In the United
29 States a number of them are administered under visiting
30 nursing agencies, for instance, but there is a great
variety and I do not think anyone has decided as yet
just the best auspices for them to be administered at
all and I think that is what we mean that, whatever the



be able to do these and things like this.

COMMISSIONER NEW YORK: I shall now

on a hospital can do it?

COMMISSIONER NEW YORK: Let me assure

the old man in bed cannot go to a phone, sometimes that

is a problem. However, we will not go into any more

detail on that.

I am now turning to recommendations

contained in paragraph 9 on page V in which you suggest

that in any health care program there should be provision

for the financing of organized home care programs and

these programs to be set up under auspices which will

provide this care for any patient where he requires a

period of hospitalization or can be cared for entirely

at home. Can you elaborate what you association means

by the term "under auspices"?

MRS. BLANK: I think at the present

time organized home care programs are sponsored on

under auspices of various groups; some are sponsored

by a hospital. The plan in Toronto is under the

Department of Public Health for the City of Toronto;

the ones in the west are under the State and the ones in

recently formed in Texas now are under a medical society.

Is not saying which auspices is the correct auspices

for a home care plan to be organized. In the United

States a number of these are administered under various

different auspices, for instance, but there is a great

variety and I do not think anyone has decided as yet

what the best auspices for them to be administered at

all and I think that is what we want that, whatever the



Leask

9777

auspices this plan should make the services available to any patient, to any specific group.

COMMISSIONER FIRESTONE: You are saying, if I understand you correctly, that in the United States some of these home care programs are co-ordinated and centred in visiting home nursings organizations?

MISS LEASK: That is right.

COMMISSIONER FIRESTONE: How would the V.O.N. feel if it were approached by a provincial government to look after such a plan for the province?

MISS LEASK: I think we would be interested in experiment or doing a pilot project in this as another type of auspices. We would not know that it was the best or that it would work but we would be very glad to try.

COMMISSIONER FIRESTONE: You have the skill, you have the organization, the will-power and brain-power so you would be a natural group to apply to.

MISS LEASK: Yes.

COMMISSIONER FIRESTONE: May I now turn to paragraph 16 on page VII and this follows up what Commissioner Van Wart was asking a little earlier:

"...there appears to be a growing
"resistance to paying for nursing care
"at home when it can be obtained in
"hospitals through the insurance plan."

You then follow up with a specific recommendation that I will not repeat as stated in your proposal and it is quite clear. Now, I take it that the reason for your recommendation is that Canada and



suggested that there should be a few more...
to any... to any... group.

COMMISSIONER: You are...

...understand you correctly, that in the United States...
...of these four... are...
...in... some...
...: That is right.

...it was approached by a...
...to... a plan for the...
...: I think we would...

...in... or...
...type of... We would not know
...the best or... but we would
...to try.

COMMISSIONER: You have the
...skills, you have the... and
...you would be a natural group to apply to.

COMMISSIONER: Now I now
...in paragraph 16 on page VII and this...
...was asking a little...
"...there... to be a...
...to...
"...which is...
"...the...
...that I will not... in your
...and...
...on your...



1
2
3
4 each province that has such an arrangement would derive
5 from it an economic benefit because it costs less to
6 look after a patient at home than it costs to keep him
7 in a hospital. Technically, that by freeing some beds
8 that would otherwise be occupied it would reduce the
9 pressure on building additional hospital bed facilities.
10 Is that the reasoning behind your recommendation in this
11 paragraph?

12 MR. JEFFERY: We all know -- I am
13 associated in the three hospitals at home as a consultant
14 and various sorts of things and I know of one hospital
15 in London who claim they have a waiting list of 1,000
16 people waiting to get in to receive treatment. Now,
17 this is not entirely a question of accommodation, sometimes
18 it is a question of nursing staff. That is another
19 part of this situation. We suggest that the net result
20 of the cost, if we can get some of these people out that
21 do not need to be there and the reason they are there
22 is two-fold, one, they do not want to go home because
23 it will cost them money and, secondly, the doctor is
24 very kind and generous and just does not feel like sending
25 them home because if he sends them home the facilities
26 are not there to provide for them in some cases. We
27 believe it would be a very useful contribution to the
28 whole economy if more careful consideration can be given
29 to this suggestion.
30

31 COMMISSIONER FIRESTONE: That is a very
32 helpful suggestion, thank you. Now, may I turn to
33 paragraph 100 on 31 in which you offer a conclusion and
34 I quote:



and that is that has such an important world-wide
 now it is a social benefit because it costs less to
 look after a patient at home than it costs to keep him
 in a hospital. Technically, that by freeing some of
 that would otherwise be occupied it would reduce the
 pressure on building additional hospitals and facilities.
 It is that the reasoning behind your recommendation in this

MR. TOLSON: We all know that

associated in the three hospitals at home as a consultant
 and various sorts of things and I know of one hospital
 in London who claim they have a waiting list of 1,000
 people waiting to get in to receive treatment.

this is not entirely a question of accommodation, is it?
 it is a question of nursing staff. That is another
 part of the situation. We suggest that the net result
 of the report, if we can get some of these people out that
 do not need to be there and the reason they are there
 is two-fold, one, they do not want to be home because
 it will cost them money and, secondly, the doctor as

very kind of person one and that does not feel like sending
 them home because if he sends them home the facilities
 are not there to provide for them in some cases. We
 believe it will be a very useful contribution to the
 whole of the more careful consideration can be given
 to this suggestion.

COMMISSIONER: That is a very

interesting suggestion, thank you. Now, may I turn to
 the question of what is which you offer a consultation and



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Jeffery

9779

"It would be necessary for special
"funds to be secured for any research
"program".

-

-

-



G/ss

Jeffrey 9780

COMMISSIONER FIRESTONE: Now, Mr. Jeffrey, what kind of research do you have in mind that V.O.N. might carry out?

MR. JEFFREY: There are many, many schemes that we feel we could. I think Miss Leask might answer that.

MISS LEASK: If I can't I will turn it over to Miss MacArthur. Mr. Chairman, I feel we have outlined for instance, certain services we feel might be explored in nursing that would have to be taken on on a private basis, and for which there would have to be special funds because they would be over and above our service. I think there are other areas that we would like to study, such as why does one community use the visiting nurse service much more than another community which seems to be of the same size and type. This is something we would like to look into. We would like to get some work on the use of personnel, for example, where we could use nursing assistants and whether we could use them more widely and also in the use of male nurses which has been discussed and the use of clinical personnel, the use of physiotherapists or consultant personnel. All these things we feel we would like to have studies on, but we have neither personnel nor the funds at the present time to do it.

COMMISSIONER FIRESTONE: When you speak here of obtaining special funds, do you have in mind, Mr. Jeffrey, Miss Leask, a grant for research from the Federal Government?

MR. JEFFREY: We are not choosey where



1947

WISCONSIN FARMERS' UNION

Letter, what kind of answer do you have in mind?

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947



Jeffrey 9781

it comes from at all.

MISS LEASK: I think we think of either Government funds or foundations funds as possibilities.

COMMISSIONER FIRESTONE: I appreciate that you are interested in research funds from any one of these sources that you have mentioned, but Mr. Jeffrey, you will appreciate this is a Royal Commission advising the Federal Government and we would appreciate it if you could give us some advice of what you would expect from the Federal Government, whether you expect research grants or whether you are satisfied with the grants you could receive from the foundations and the Provincial Government. If so, please say so and then there is no request for research grants to the V.O.N.

MR. JEFFREY: Let me put it this way, Mr. Chairman, we have searched long for such funds, and so far haven't been able to obtain them. We do believe that we could prove effectively whether one of these projects would or would not work before it became a matter of law by doing some research properly financed. The whole project would be subject to supervision as may be set down. We believe we have the knowledge. We might obtain the staff if we had the funds to do so and we think we could do it very expeditiously and effectively.

MISS LEASK: Mr. Chairman, could I add to this I think a national organization is in a rather difficult position in regard to grants. Most of the health grants are provided provincially and the national organization does not have access for its national office to these grants and therefore our national



10/11/51

It is from all.

10/11/51: I think we think of things

Government funds or foundations funds as possible.

that we are interested in research funds from any one of these sources that you have mentioned, but Mr. Belmont,

you will appreciate that is a Royal Commission advising

the National Government as to what we would appreciate it if

you could give us some advice of what you could expect

to be in position you are satisfied with the "from a you

could receive from the foundations and the Provincial

Government. If so, please say so and then there is no

10/11/51: Let me put it this way,

Mr. Belmont, I have, perhaps, only two good things, and

that we could prove effectively whether one of these

is a good thing or not. I would like to work before it is a matter

of law but I have some research properly financed, the

what we would be subject to supervision as well as

costs. To believe we have the knowledge, it might

be that the staff is not the time to do so and no

thing we could do it very expeditiously and effectively

10/11/51: Mr. Belmont, could I

ask to tell I think a national organization as in a

rather difficult position in regard to "state" and

the public groups are provided provisionally and the

national organization does not have access for its

and that is to those groups and therefore our national



Leask 9782

office could not apply to the Provincial Government for grants. I would feel if a grant was available Federally it would be of great assistance to the national organization.

COMMISSIONER FIRESTONE: Well, the Federal Government is making a number of research grants to universities, to associations, to individuals, to professionals for particular projects. What I am asking for is whether your organization has a specific recommendation to make that the Federal Government give you an initial research grant of X thousand dollars to start off your program.

THE CHAIRMAN: Just start with the X dollars.

MISS LEASK: Mr. Chairman, I don't think we have one outlined. Is this what Mr. Firestone means?

COMMISSIONER FIRESTONE: Not outlined, but do you have any suggestions that the Federal Government provide V.O.N. with research grants to undertake some research?

MISS LEASK: I would feel, yes.

COMMISSIONER FIRESTONE: Have you a suggestion what the initial amount should be?

MISS LEASK: No, I would be glad to think about it.

COMMISSIONER FIRESTONE: Perhaps I should turn the question over to Mr. Jeffrey as a businessman. There are various amounts from X to Z.

COMMISSIONER McCUTCHEON: Any given



100-100000-100000

1. The first of the two projects is a study of the
2. second project is a study of the
3. third project is a study of the
4. fourth project is a study of the
5. fifth project is a study of the

6. The first of the two projects is a study of the
7. second project is a study of the
8. third project is a study of the
9. fourth project is a study of the
10. fifth project is a study of the

11. The first of the two projects is a study of the
12. second project is a study of the
13. third project is a study of the
14. fourth project is a study of the
15. fifth project is a study of the

16. The first of the two projects is a study of the
17. second project is a study of the
18. third project is a study of the
19. fourth project is a study of the
20. fifth project is a study of the

21. The first of the two projects is a study of the
22. second project is a study of the
23. third project is a study of the
24. fourth project is a study of the
25. fifth project is a study of the

26. The first of the two projects is a study of the
27. second project is a study of the
28. third project is a study of the
29. fourth project is a study of the
30. fifth project is a study of the



Jeffrey 9783

amount, I take it.

COMMISSIONER FIRESTONE: Just trying to be helpful, would you be thinking of something initially of, say, \$50,000.00.

MR. JEFFREY: We could bring up and suggest some very worthwhile projects. I don't know how close we could come to the actual figure, but we could come forward with something. We weren't asked for that in this brief. Our staff have been working day and night, as I am sure others have, to try and prepare an instructive brief for you. We would have to go at it again.

COMMISSIONER FIRESTONE: Mr. Jeffrey, you appreciate the more concrete the recommendations are, the easier you are making the job for the Commission to understand what you have in mind and how it could be put into practice. If it were possible to ask your staff and your associates to give a little further thought on what the research program would entail, the people that would be involved, how much money would be required initially, if this could be sent in the form of a written communication to Secretary in the next several months, this would give a concreteness to your recommendations that might be helpful to us, and perhaps, ultimately to you.

MR. JEFFREY: We would be delighted to do so.

COMMISSIONER FIRESTONE: Thank you very much, Mr. Jeffrey, Miss Leask.

THE CHAIRMAN: Miss Girard.

COMMISSIONER GIRARD: Mr. Chairman, I believe most of my questions have been answered along



...I take it.

...I would not be thinking of something like that.

...I would like to see it.

...I don't know how

...to the actual figures, but we could

...be forward with something. We haven't a lot of time

in this part of it. Our staff have been working day and night

as I am sure others have, to try and prepare an inventory

brief for you. We would have to go at it again.

...I am sure the more concrete the recommendations are,

the easier you are making the job for the Commission to

understand what you have in mind and how it could be put

into practice. It is more possible to ask your staff and

your associates to give a little further thought on what

the new program would entail, the people that would

be involved, how much money would be required initially,

it could be sent in the form of a written communi-

cation to be sent in the next several months, this would

give a concreteness to your recommendations that might

be helpful to us, and perhaps, ultimately to you.

MR. LUTHER: I would be delighted to

...I am sure that you very

...I am sure that you very

I believe most of my questions have been answered today



Leask 9784

the line. I just have one and this does not entail a future plan. This is something that is ongoing. On Page I in your recommendations that referral programs be initiated in all hospitals and that provision be made in hospital budgets for payment of all costs. Supposing we were to start a referral program in our hospital, what items would we put in our budget for the costs that would be entailed in a referral program?

MISS LEASK: Mr. Chairman, I feel this would be office space, the actual physical equipment for the office of the referral person, secretarial help, telephone service and stationery, and that type of equipment, and then the payment for the time of the nurse.

COMMISSIONER GIRARD: Is this generally full-time?

MISS LEASK: It depends on the size of the hospital, Miss Girard. We have a full-time person in the two hospitals in Montreal and several of the other hospitals are part-time. I think we also have a full-time in Hamilton.

MISS MacARTHUR: Half-time.

COMMISSIONER GIRARD: Do any of them have more than the one full-time?

MISS LEASK: We haven't as yet had more than one full-time person. This may be developed. The attempt in Montreal and in Edmonton and Calgary, these are on a different basis in those places. In Montreal the hospital pays the salary of the public health nurse. In Calgary and Edmonton they pay on an hourly basis.



... I just have one and this does not really
 ... This is something that is ongoing, and
 ... in your recommendations that referral programs be
 ... in all hospitals and that provision be made
 ... in hospital budgets for payment of all costs. ...
 ... to start a referral program in our hospital, what
 ... we put in our budget for the costs that
 ... in a referral program?

MR. LIAISON: Mr. Chairman, I feel this
 ... the actual physical examination for
 ... the office of the referral person, secretarial help,
 ... telephone service and stationery, and that type of equip-
 ... ment, and then the payment for the time of the person.
 ... is this generally?

MISS LIAISON: It depends on the size
 ... the hospital, that kind of thing. We have a full-time person
 ... in the two hospitals in Montreal and several of the other
 ... I think we also have a full-
 ... time in Montreal.

MISS MARCHAND: ...
 ... Do any of them
 ... the one full-time?

MISS LIAISON: We haven't as yet had
 ... more than one full-time person. This may be developed
 ... the attempt in Montreal and in Edmonton and Calgary,
 ... on a different basis in those places, in
 ... the hospital pays the salary of the person
 ... In Calgary and Edmonton they pay on a
 ... basis.



Leask 9785

COMMISSIONER GIRARD: V.O.N. nurse?

MISS LEASK: A qualified person. In other hospitals they pay on an hourly basis for the time of the nurse in the hospital.

COMMISSIONER GIRARD: Thank you very much, Miss Leask.

THE CHAIRMAN: Thank you very much, Mr. Jeffrey and associates.

MR. JEFFREY: Thank you very much.

THE CHAIRMAN: You are very helpful, both at the national and provincial level. We are very grateful to you.

We will take a short recess now and then proceed with the next submission.

---Short Recess.

THE CHAIRMAN: Ladies and gentlemen, if you will come to order we will proceed.

THE SECRETARY: Mr. Chairman, the next submission is that of the Association of Canadian Medical Colleges which will be known as Exhibit 267. Dr. C.B. Stewart will present the submission and Dr. Ettinger will speak to a further submission which I have given to you which is known as Exhibit 267A. There will also be a short statement from Dr. Stewart.



Thank you very much.

MISS LEACH: A qualified person. In other words they pay on an hourly basis for the time of the nurse in the hospital.

COMMISSIONER GIBBARD: Thank you very much.

THE CHAIRMAN: Thank you very much. Mr. Jeffrey and associates.

MR. JEFFREY: Thank you very much.

THE CHAIRMAN: You are very helpful, both at the national and provincial level. We are very grateful to you.

We will take a short recess now and then proceed with the next submission.

---Short Recess---

THE CHAIRMAN: Ladies and gentlemen, if you will come to order we will proceed.

THE SECRETARY: Mr. Chairman, the next submission is that of the Association of Canadian Medical Colleges which will be known as Exhibit 267. Dr. C. A. Stewart will present the submission and Mr. Stimpson will speak to a further submission which I have given to you which is known as Exhibit 267A. There will also be a short statement from Dr. Stewart.



Stewart 9786

THE CHAIRMAN: Dr. Stewart, I was going to suggest we wait a minute until we get a little less opposition.

SUBMISSION OF
THE ASSOCIATION OF CANADIAN MEDICAL COLLEGES

---EXHIBIT NO. 267: Submission of the Association of Canadian Medical Colleges.

---EXHIBIT NO. 267A: Staff and Facilities in the Basic Medical Sciences in Canadian Medical Schools.

APPEARANCES:

CHESTER BRYANT STEWART, M.D.
Dean, Faculty of Medicine, Dalhousie University
PRESIDENT, THE ASSOCIATION OF CANADIAN MEDICAL COLLEGES

LLOYD GRENFELL STEVENSON, M.D.
Dean, Faculty of Medicine, McGill University
2nd VICE-PRESIDENT, THE ASSOCIATION OF CANADIAN MEDICAL COLLEGES

GEORGE HAROLD ETTINGER, M.D.
Dean, Faculty of Medicine, Queen's University
PAST PRESIDENT, THE ASSOCIATION OF CANADIAN MEDICAL COLLEGES

DR. STEWART: Mr. Chairman and Members of the Commission, the Association of Canadian Medical Colleges is very happy to have this opportunity to meet with you, sir, and Members of the Commission to discuss the brief prepared by our Association. If I may, I shall read the summary and conclusions and recommendations with



1954

THE CHAIRMAN: Dr. Stewart, I was
going to suggest we wait a minute until we get a little
less opposition.

2 U N I T S I O N C T
THE ASSOCIATION OF CANADIAN MEDICAL COLLEGES

Submission of the Associa-
tion of Canadian Medical

Staff and facilities in
the basic medical sciences
in Canadian medical schools.

---EXHIBIT NO. 187A:

CHRISTIE BRYANT STEWART, M.D.
Dean, Faculty of Medicine, Dalhousie University
PRESIDENT, THE ASSOCIATION OF CANADIAN MEDICAL

LLOYD GREENLEAF STEVENSON, M.D.
Dean, Faculty of Medicine, McGill University
2nd VICE-PRESIDENT, THE ASSOCIATION OF CANADIAN

Dean, Faculty of Medicine, Queen's University
1ST VICE-PRESIDENT, THE ASSOCIATION OF CANADIAN

DR. STEWART: Mr. Chairman and Members

of the Commission, the Association of Canadian Medical
Colleges is very happy to have this opportunity to meet
with you, sir, and members of the Commission to discuss
the brief prepared by our Association. If I may, I shall
read the summary and conclusions and recommendations with



Stewart 9787

just a brief comment on one or two of them as we go along.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

The Association of Canadian Medical Colleges, whose members are the Deans of the Faculties of Medicine in the Canadian Universities, finds that the medical schools of Canada do not graduate the number of physicians necessary to provide adequate medical service for our citizens, and that there is no current provision for increasing the volume of graduates as the population expands. There has been, until recently, I think that the word "until" is added, a reluctance of young Canadians of good academic promise to apply for admission to Faculties of Medicine; I would comment this trend very definitely seems to have changed and even as we have cleared this, as we are now fairly along with the selection of the students for the coming September's classes, it would appear the trend is definitely upward both with respect to the numbers, and I think most of us agree with respect to the quality. This still doesn't mean, however, that the numbers are adequate yet, but the trend is in the right direction.

COMMISSIONER BALTZAN: Across the country?

DR. STEWART: It seems to be true across the country.

Possible reasons for this are suggested such as length of or cost of training. We shall qualify our comments on that later.

The medical schools have inadequate



Statement

...a total of 125,000 of which two of them are...

SUMMARY OF TRENDS AND PROJECTIONS

The Association of Canadian Medical...

...whose members are the heads of the faculties of
 ...in the Canadian universities, finds that the
 ...of Canada do not give the number of
 ...to provide adequate medical services
 ...that there is no current provision
 ...the volume of graduates as the population
 ...there has been, until recently, a trend that the
 ...added, a reluctance of young Canadians
 ...to apply for admission to
 ...I would comment this trend very
 ...to have changed and even as we have
 ...the selection of
 ...it would
 ...both with respect
 ...I think most of us agree with respect
 ...however, that
 ...but the trend is in the

ACROSS THE

IT SEEMS TO BE

...reasons for this are suggested
 ...length of or cost of training. We shall qualify
 ...later.
 The medical schools have indicated



Stewart 9788

physical facilities to educate more students; the salaries of teachers are low; the schools are understaffed; and there is no prospect of producing, in Canada, the number of physicians essential to the health of our people unless steps are taken to expand the facilities of the existing schools, create new medical schools, attract and hold medical teachers and scientists in the universities, and reduce the cost to the student of medical education. Our recommendations centre on this, first, the first dealing with curriculum.

RECOMMENDATIONS

CURRICULUM

That, until substantial research in medical education indicates the need of serious modification, there be no reduction in the total duration of undergraduate medical studies.

Recommendations have been made, sir, by a number of people that the length of the medical course should be considered. We emphasize the point that the university education, the medical course in universities has been four years for a very long time, almost 50 years, I think. The increase that has been frequently quoted has come from an increase of the premedical requirements before admission to the medical school and the relatively long period of specialty training. Some suggestions for shortening the course have been made and we refer to some on Page 7. These are suggestions only for study, and we would like to emphasize the Association of Canadian Medical Colleges is not recommending the introduction of any of them. Some of us are doubtful as to the feasibility.



physical facilities to educate more students; the salaries of teachers are low; the schools are understaffed; and there is no prospect of producing, in Canada, the number of physicians essential to the health of our people unless steps are taken to expand the facilities of the existing schools, create new medical schools, attract and train medical teachers and scientists in the universities, and reduce the cost to the student of medical education. Our recommendations centre on this, first, the first dealing with curriculum.

That, until substantial research in medical education indicates the need of serious modification, there be no reduction in the total duration of undergraduate medical studies. Recommendations have been made, sir, by a number of people that the length of the medical course should be considered. We emphasize the point that the university education, the medical course in universities has been four years for a very long time, almost 50 years, I think. The increase that has been frequently quoted has come from an increase of the premedical requirements before admission to the medical school and the relatively long period of specialty training. Some suggestions for shortening the course have been made and we refer to some on Page 7. These are suggestions only for study, and we would like to emphasize the Association of Canadian Medical Colleges is not recommending the introduction of any of them. Some of us are doubtful as to the feasibility



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Stewart 9789

We do point out this need for further study. One of the developments within the last few weeks has been the development of a secretariat of medical education in the Association of Canadian Medical Colleges, the Royal College of Physicians and Surgeons and the Canadian Medical Association, the organization in operating under the Association of Canadian Medical Colleges in which we hope that many of these very important fields of medical education, methods of solving the problems may have further study.



Stewart 9712

is do point out this need for further study. One of the
developments within the last few weeks has been the
appointment of a secretariat of medical education in the
College of Physicians and Surgeons and the Canadian
Medical Association, the organization in operating under
the Association of Canadian Medical Colleges in which
we hope that many of these very important fields of
medical education, methods of solving the problems may

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30



Stewart

9790

MANPOWER

S3 formation: 11. That, in order to assure the training, in Canada, of the number of physicians necessary to serve the expanding population, and I would insert, to serve adequately the existing population, steps be taken promptly to establish two new medical schools in addition to the Faculty of Medicine in the University of Sherbrooke, and, within ten years, an additional two schools. Expansion of facilities in the existing schools should also be contemplated. In fact, we feel should definitely be undertaken and given quite a high priority. I would comment on this further, that there are some areas, some medical schools which may not have the clinical facilities and in which the other essential requirements may not make it feasible to expand. Whereas, there are still others that could expand and increase the number of graduates.

It is, therefore, difficult to make a generalization which will cover the whole country, but we feel that it should have a high priority.

S4 formation: 12. That, to encourage young students to enter the study of medicine, more liberal scholarships and bursaries be established, and fees for instruction be reduced or abolished.

S5 formation: 13. That, in order to attract gifted young graduate students to careers in teaching and research in medical science, larger stipends be offered by universities, with a smaller difference than now exists between the earnings offered to the basic scientist and to the clinician. The supplementary exhibit which



23

1. That, in order to assure the training, in Canada, of the number of physicians necessary to serve the expanding population, and I would insert, to serve adequately the existing population, steps be taken promptly to establish two new medical schools in addition to the Faculty of Medicine in the University of Toronto, and, within ten years, an additional two schools. Expansion of facilities in the existing schools should also be contemplated. In fact, we feel should definitely be undertaken and given quite a high priority. I would comment on this further, that there are some areas, some medical schools which may not have the clinical facilities and in which the other essential requirements may not make it feasible to expand. Whereas, there are still others that could expand and increase the number of graduates. It is, therefore, difficult to make a generalization which will cover the whole country, but we feel that it should have a high priority.

2. That, to encourage young students to enter the study of medicine, more liberal scholarships and bursaries be established, and fees for instruction be reduced or abolished.

3. That, in order to attract gifted young graduate students to careers in teaching and research in medical science, larger stipends be offered by universities, with a smaller difference than now exists between the earnings offered to the basic scientist and to the clinician. The supplementary exhibit which



Stewart

9791

Dr. Ettinger will present later provides the additional information which we feel may be of value to your Commission on this point, sir.

S6 4. That the universities have their budgets for salaries raised sufficiently to permit them to increase the number of full-time teachers in both the basic sciences and clinical sciences.

CLINICAL TEACHING

S7 1. That the Hospital Insurance Act be amended to recognize teaching hospitals, which shall have the obligation to establish teaching units in the interest of the universities which support Faculties of Medicine, and that these hospitals be provided with such financial support as will ensure the availability of facilities for teaching undergraduate and graduate medical students in the teaching units and in the out-patient departments. The present legislation leaves this matter to the province. In some provinces it has been well taken care of. Teaching hospitals are considered on a separate basis. In others, there are problems both with respect to higher cost in an institution which is providing exemplary medical care and teaching and also important in connection with the grants for building because the community may have money available, and has a source from which it can obtain additional money since the Federal and Provincial grants are, of course, providing only a relatively small fraction of the cost of building the university. A university hospital has difficulty in obtaining what is usually the community's share of that.

... The Government will present later provided the information which we feel may be of value to your Commission on this point, sir.

4. That the universities have their budgets for salaries raised sufficiently to permit them to maintain the number of full-time teachers in the basic sciences and clinical sciences.

TEACHING HOSPITALS

1. That the Hospital Insurance Act be amended to recognize teaching hospitals, which shall have the obligation to establish teaching units in the interest of the universities which support Faculties of Medicine, and that these hospitals be provided with such financial support as will ensure the availability of facilities for teaching undergraduate and graduate medical students in the teaching units and in the out-patient departments. The present legislation leaves this matter to the province. In some provinces it has been well taken care of. Teaching hospitals are considered on a separate basis. In others, there are problems both with respect to higher cost in an institution which is providing exemplary medical care and teaching and also important in connection with the grants for building because the community may have money available, and has a source from which it can obtain additional money since the Federal and Provincial Grants are, of course, providing only a relatively small fraction of the cost of building the university. A university hospital not infrequently is obtaining what is usually the community's share of this.



Stewart

9792

1
2
3
4 S8 2. That, in the combined teaching
5 units in the teaching hospitals associated with each
6 medical school, there be sufficient beds to provide a
7 minimum of ten, and a maximum of twenty, patients for
8 each registered student in the final year of the medical
9 course, and that out-patient departments be provided
10 with facilities for treating as many new patients each
11 day as there are students who are taught in the depart-
12 ments. That formula, in other words, means that if a
13 school is graduating approximately 65 students a year,
14 they should have 650 teaching beds in all of the
15 hospitals; not in any one, necessarily, in teaching units
16 in which the patients are under the care of a team of
17 an active staff member and the student, and graduate in
18 training. Also, in the out-patient department of the
19 same institutions, if there were 65 students, there
20 should be approximately 65 new patients each day, or
21 one per student. This is of vital necessity because
22 the medical education is still, in part, an apprentice-
23 ship system and any system - any development in the
24 field of medical economics, of insurance, whether they
25 are voluntary plans or governmental plans, are providing
26 that in a limited number but adequate number of hospitals
27 there be patients who are under the care of these
28 teaching teams. Otherwise, medical education would
29 suffer.
30

26 S9 3. That the university shall be repre-
27 sented on the governing board of each of its associated
28 teaching hospitals, and shall share responsibility with
29 the hospital for the appointment of the medical staff of
30

That, in the combined teaching and hospital work, there be sufficient beds to provide a minimum of ten, and a maximum of twenty, patients for each registered student in the final year of the medical course, and that out-patient departments be provided with facilities for treating as many new patients each day as there are students who are taught in the department. That formula, in other words, means that if a school is educating approximately 65 students a year, they should have 650 teaching beds in all of the hospital: not in any one, necessarily, in teaching units in which the patients are under the care of a team of an assistant staff member and the student, and graduate in training. Also, in the out-patient department of the same institution, if there were 65 students, there should be approximately 65 new patients each day, or one per student. This is of vital necessity because the medical education is still, in part, an apprenticeship system and any system - any development in the field of medical education, of insurance, whether they are voluntary plans or governmental plans, are providing that in a limited number not adequate number of hospitals there be patients who are under the care of these teaching teams. Otherwise, medical education will be

3. That the university shall be represented on the governing board of each of its associated teaching hospitals, and shall share responsibility with the hospital in the appointment of the medical staff of



Stewart

9793

the teaching units and out-patient departments.

S10 4. That the universities be provided with funds sufficient to remunerate the part-time teachers, in proportion to the services rendered.

Tremendous contribution has been made over the years in every medical centre in Canada through free medical care associated with patients as well as teaching in the clinical fields.

GRADUATE EDUCATION

S11 1. That the existing facilities for graduate training in the medical and surgical specialties be maintained and extended.

S12 2. That the Canadian universities assume a greater responsibility in graduate training, and that funds be provided for them to employ the number of specially qualified teachers necessary to organize and direct the program.

If I might comment on this, the Royal College of Physicians and Surgeons of Canada pass on the hospitals for residency training in specialties, and have asked that the university take greater responsibility to assist them in this field, and we agree that there is a need of consultation and for working this whole field over together, because this is a joint responsibility and should be a joint responsibility of both the Royal College and the universities.

S13 3. That the principle of graded responsibility for patient care under supervision be recognized as the most satisfactory feature of a residency training program. In fact, I think we should say the essential



the teaching units and out-patient departments.
 4. That the universities be provided
 with funds sufficient to remunerate the part-time
 teachers, in proportion to the services rendered.
 Tremendous contribution has been made
 over the years in every medical centre in Canada through
 free medical care associated with patients as well as
 teaching in the clinical fields.

1. That the existing facilities for
 graduate training in the medical and surgical specialties
 be maintained and extended.

2. That the Canadian universities
 assume a greater responsibility in graduate training,
 and that funds be provided for them to employ the
 number of specially qualified teachers necessary to
 organize and direct the program.

If I might comment on this, the Royal
 College of Physicians and Surgeons of Canada pass on
 the hospitals for residency training in specialties,
 and have asked that the university take greater responsi-
 bility to assist them in this field, and we agree that
 there is a need of consultation and for working this
 whole field over together, because this is a joint
 responsibility and should be a joint responsibility of
 both the Royal College and the universities.

3. That the principle of graded responsi-
 bility for patient care under supervision be recognized
 as the most satisfactory feature of a residency training
 program. In fact, I think we should say the essential



Stewart

9794

feature.

S14 4. That residents who undertake a year of training in a basic science department or a clinical investigation unit be given an appropriate stipend.

It's rather shocking to realize that a man who may have had anywhere from 8, 10, sometimes 12 years of university education may be earning something of the order of \$2,000 to \$3,000.

S15 5. That, in teaching hospitals, the establishment of internes and residents be kept at an optimum number, as determined by recognized accrediting agencies.

S16 6. That teaching hospitals be enabled to provide adequate remuneration to internes and residents, and that the salaries of residents be increased at each stage of their training, in keeping with the increasing value to patient care as the training advances.

S17 7. That the urgent problem of providing an adequate and representative supply of patients for the teaching units of hospitals affiliated with universities be a matter for intensive and continuing study by Government, Hospital Services Commissions, medical educators and the Canadian Medical Association.

This, of course, is a further comment on the point I made about the necessity of the teaching unit, and out-patients' departments.

CONTINUING MEDICAL EDUCATION

S18 That it be recognized that the responsibility of a medical school to provide staff to participate in programs of continuing medical education requires the



1940

4. That residents who undertake a year of training in a basic science department or a clinical investigation unit be given an appropriate stipend. It's rather shocking to realize that a man who may have had anywhere from 8, 10, sometimes 12 years of university education may be earning something of the order of \$2,000 to \$3,000.

5. That, in teaching hospitals, the establishment of internships and residents be kept at an optimum number, as determined by recognized accrediting

6. That teaching hospitals be enabled to provide adequate remuneration to internists and residents, and that the salaries of residents be increased at each stage of their training, in keeping with the increasing value to patient care as the training advances.

7. That the urgent problem of providing an adequate and representative supply of patients for the teaching units of hospitals affiliated with universities be a matter for intensive and continuing study by Government, Hospital Services Commissions, medical education, and the Canadian Medical Association.

8. That, of course, is a further comment on the point I made about the necessity of the teaching unit, and 'out-patient' departments.

9. That it be recognized that the responsibility of a medical school to provide staff to participate in programs of continuing medical education requires the



Stewart

9795

1
2
3 university to provide sufficient members of staff to
4 discharge this as well as the intramural function.

5 In our own medical school, we have the
6 largest program, I think, of this type of education to
7 maintain, or to help the practising physicians of our
8 constituency keep up to date in the rapidly expanding
9 field of medicine.

10 This is a tremendous strain upon our
11 clinical staff to take on this additional burden, as
12 well as under-graduate teaching and additional funds
13 should be provided so that we can enlarge the staff to
14 do an adequate job in this field.

14 RESEARCH

15 S19 1. That the Government of Canada
16 provide much larger allocations for medical research in
17 the university medical centres and teaching hospitals.

18 The United States of America has a
19 population of approximately ten times ours, but has
20 one hundred times the amount of money available for
21 medical research this year. A great deal of support of
22 medical research in Canada is being done from United
23 States funds.

24 We feel that we should not only support
25 medical research in Canada more adequately, but if we
26 do not do so, we will lose, and we have lost, a great
27 many of our most promising research men.

28 S20 2. That the Government continue to
29 support medical research in the universities and teaching
30 hospitals, and make no plans, at present, to establish
research centres independent of universities.



University to provide sufficient members of staff to discharge this as well as the internal function. In our own medical school, we have the largest program, I think, of this type of education to maintain, or to help the practicing physicians of our country keep up to date in the rapidly expanding field of medicine.

This is a tremendous strain upon our clinical staff to take on this additional burden, as well as undergraduate teaching and additional funds should be provided so that we can enlarge the staff to do an adequate job in this field.

RESEARCH

1. That the Government of Canada provide much larger allocations for medical research in the university medical centres and teaching hospitals. The United States of America has a population of approximately ten times ours, but has one hundred times the amount of money available for medical research this year. A great deal of support of medical research in Canada is being done from United States funds.

We feel that we should not only support medical research in Canada more adequately, but if we do not do so, we will lose, and we have lost, a great many of our most promising research men.

2. That the Government continue to support medical research in the universities and teaching hospitals, and make no plans, at present, to establish research centres independent of universities.



Stewart

9796

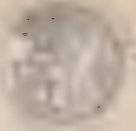
The centralization of research facilities might, in some instances, move research ahead a little more rapidly but with the shortages of teachers and of research personnel in the universities, we feel that the contact should still be with students and that the personnel, the research personnel available, should have contact with students and that until the university facilities are built up much more adequately, separate governmental units for research in specific fields of medicine should not be encouraged.

S21 3. That the administration of funds provided by Government for medical research be simplified to provide greater flexibility and stability to the programs.

S22 4. That consideration be given to the following modification of the present programs of research support:

(a) A substantial increase in the number and size of institutional research grants. Most grants are made to the individual to do a specific piece of research on a specified project. Recently the Medical Research Council has provided grants to the Deans of the medical schools of \$8,000 a year for additional and unforeseen research expenditures.

(b) Liberal support for the institution and maintenance of clinical



The centralization of research facilities

in this field, in some instances, move research toward a little more readily but with the shortage of research and of research personnel in the universities, we feel that the report should still be with studies and that the personnel, the research personnel available, should have contact with students and that until the university facilities are built up much more adequately, separate governmental units for research in specific fields of medicine should not be encouraged.

3. That the administration of funds provided by Government for medical research be simplified to provide greater flexibility and stability to the

4. That consideration be given to the

following modification of the present program of

research support:

(a) A substantial increase in the number and size of institutional

need to the individual to do a

specific piece of research on a

specific project. Recently the

Medical Research Council has

provided grants to the order of

the medical schools of \$2,000 a

year for additional and necessary

research expenditures.

(b) Direct support for the training and maintenance of clinical



Stewart

9797

investigation units in the teaching hospitals.

(c) The institution of training grants and of part-time fellowships.

(d) The establishment of senior fellowships with fixed tenure not to exceed five years, with liberal stipends, for scientists who may aspire to research associateships.



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50

Stewart
1937

investigation units in the testing
hospitals.
(c) The institution of training
grants and of part-time fellowships.
(d) The establishment of senior
fellowships with fixed tenure not to
exceed five years, with liberal
stipends, for scientists who may
aspire to research associatehips.



u/hm 1 9798

2
3
4 (e) A considerable increase in the
5 number of research associateships as offered by the
6 Medical Research Council, with permission for supple-
7 mentary earnings up to \$3,000 per annum.

8 Dr. Stevenson, who has a special
9 interest in this, may comment on some of these suggestions
10 concerning research, sir.

11 S23 5. That the recommendation of the
12 "Farquharson Report" relating to capital grants for
13 building be implemented without delay.

14 In the Farquharson Report, report
15 of the special committee on research of the Federal
16 Government, the recommendation was made that the
17 medical schools and the teaching hospitals, all of which
18 need a great increase in their research facilities,
19 should have federal government assistance.

20 The estimates made at that time --
21 and they are now somewhat outdated and we are collecting
22 additional estimates on this -- the estimates were
23 then for 25 million dollars for research facilities
24 alone in the medical schools and \$12 million for research
25 facilities in the affiliated hospitals. These, of
26 course, are now outdated and too small.

27 Finally, sir, we were adding a
28 recommendation: That the purchase of equipment for
29 medical education and research be exempt from taxation.
30 I would ask Dr. Stevenson if he would comment on that
when he speaks on other aspects of research.

THE CHAIRMAN: Thank you, Dr. Stewart.
Dr. Stevenson.

(e) A considerable increase in the number of research associations is offered by the Medical Research Council, with provision for supplementary earnings up to \$3,000 per annum.

Dr. Stevenson, who has a special

interest in this, may comment on some of these suggestions concerning research, sir.

5. That the recommendation of the "Paraphrase Report" relating to capital grants for building be implemented without delay.

In the Paraphrase Report, report

of the special committee on research of the Federal

Government, the recommendation was made that the

medical schools and the teaching hospitals, all of which

need a great increase in their research facilities,

should have Federal Government assistance.

The estimates made at that time --

and they are now somewhat outdated and we are collecting

additional estimates on this -- the estimates were

then for 25 million dollars for research facilities

alone in the medical schools and \$12 million for research

facilities in the affiliated hospitals. These, of

course, are now outdated and too small.

Finally, sir, we were adding a

recommendation: That the purchase of equipment for

medical education and research be exempt from taxation.

I would ask Dr. Stevenson if he would comment on that

when he speaks on other aspects of research.

THE CHAIRMAN: Thank you, Dr. Stewart.



Stevenson

9799

1
2
3
4 DR. STEVENSON: Thank you very much,
5 sir, I feel that the association should apologize for
6 adding those points which Dr. Stewart has referred to at
7 the end. We should have been aware of this earlier.
8 The reason that it came to our attention with special
9 force recently is that I have been trying to add up
10 the costs of the equipment going to a new research
11 building at McGill University and the taxation, both
12 federal and provincial, for this equipment, and struck
13 by the size of this figure I enquired into the matter
14 a little bit and I find if a certain kind of medical
15 research work was to be done across the street in a
16 teaching hospital equipment would be tax free; if this
17 work is carried by the same man by the same equipment
18 in a university laboratory it will be taxed by the
19 provincial government, even by the federal government;
20 very frequently there will be a double tax on such
21 equipment. This seems to me to be a scandalous situation,
22 that the research dollar is over a piece trimmed in
23 this fashion when research funds in Canada are as
24 inadequate as they now are.

25 If the Farquharson Report can be
26 implemented more fully -- some of these recommendations
27 have already taken effect -- the space can be provided
28 with capital grants for enlarging Canada's research
29 undertakings.

30 It is sometimes said that the United
States offers no real model for us, that they do things
on a very large scale south of the border. But as
Dean Stewart has indicated, the relationship is one which



Dr. STEVENSON: Thank you very much.

Now, I feel that the association should apologize for sending those papers which Dr. Stewart has referred to at the end. We should have been aware of this earlier. The reason that it came to our attention with special force recently is that I have been trying to add up the costs of the equipment going to a new research building at McGill University and the taxation, both federal and provincial, for this equipment, and struck by the size of this figure I enquired into the matter a little bit and I find it a certain kind of medical research work was to be done across the street in a teaching hospital equipment would be tax free; if this work is carried by the same man by the same equipment in a university laboratory it will be taxed by the provincial government, even by the federal government; very frequently there will be a double tax on such equipment. This seems to me to be a scandalous situation, that the research dollar is over a piece trimmed in this fashion when research funds in Canada are as inadequate as they now are.

If the Thompson report can be implemented more fully -- some of these recommendations have already taken effect -- the space can be provided with capital grants for enlarging Canada's research

It is sometimes said that the United States offers no real model for us, that they do things on a very large scale south of the border. But as I am Stewart has indicated, the relationship is one which



Stevenson

9800

1
2
3
4 cannot be the cause of any pride in Canada with reference
5 to the relative size of population. This can also
6 be figured out in terms of gross national products,
7 and the amount of money that has been provided for
8 medical research in Canada has been very small indeed
9 by comparison not only with the United States but other
10 countries which are closer, perhaps, economically with
11 Canada.

12 I think it is referred to in the body
13 of our submission that there is a very curious contrast
14 between Canada and United States in the way research
15 moneys are divided up generally. In the United States
16 five times as much money is spent on medical research
17 as on agricultural research; in Canada three times is
18 spent as much on agricultural research as on medical
19 research. So it is not so much a matter of amounts in
20 these two countries in financing medical research. This
21 year the Medical Research Council of Canada had 4.3
22 million dollars available for what is called basic
23 research in medicine. The Department of National Health
24 and Welfare is reviewing and amending its granting
25 policy and withdrawing more and more from this basic
26 field. If this 4.3 million dollars were increased by
27 \$700,000.00 it would reach the total of what we spend
28 on sport, and I wonder whether Canada considers that
29 sport is so much more important than medical research
30 to the national economy and to the national welfare.

The suggestions made that the alteration
in the way in which funds should be granted and
administered are modelled in part on the development in



cannot be the cause of any pride in Canada with reference to the relative state of population. This can also be figured out in terms of gross national products, and the amount of money that has been provided for medical research in Canada has been very small indeed by comparison not only with the United States but other countries which are closer, perhaps, economically with

I think it is referred to in the body of our submission that there is a very curious contrast between Canada and United States in the way research moneys are divided up generally. In the United States five times as much money is spent on medical research as on agricultural research; in Canada three times is spent as much on agricultural research as on medical research. So it is not so much a matter of amounts in these two countries in financing medical research. This year the Medical Research Council of Canada had \$4.8 million dollars available for what is called basic research in medicine. The Department of National Health and Welfare is reviewing and amending its granting policy and withdrawing more and more from this basic field. If this \$4.3 million dollars were increased by \$700,000.00 it would reach the total of what we spend on sport, and I wonder whether Canada considers that sport is so much more important than medical research to the national economy and to the national welfare. The suggestions made that the allocation in the way in which funds should be granted and administered are modelled in part on the development in



Stevenson

9801

1
2
3
4 the United States. In some ways we are closer to the
5 British model. It has been suggested here that we
6 should not do what has been done in the United Kingdom,
7 the setting up of independent research centres. Dr.
8 Stewart has suggested the reason for this. Such centres
9 would have a tendency to drain off people from the
10 universities where it is very badly needed. We must
11 look to the universities to provide men who are going
12 to be the teachers in these new and expanding medical
13 schools, in the basic science departments as well as
14 on the clinical side, and the development of research
15 in the universities rather than in separate centres is,
16 I think, rather fundamentally important, and to do this
17 a great deal more money is needed.

18 I would like to come back to this
19 question of taxation, which seems to me to be relatively
20 easily remedied. The hospitals across the country,
21 if I am not mistaken, have been free from this burden
22 of taxation on the research side. I can see no reason
23 in logic or revelation why models adjoining these
24 hospitals should not be treated similarly; and if grants
25 are given for cancer and heart disease, then this amount
26 should not be reduced by taxation.

27 THE CHAIRMAN: Thank you, Dr. Stevenson.

28 DR. ETTINGER: Mr. Chairman, members
29 of the Commission, I wish to thank you for the opportunity
30 of submitting exhibit A. It is entitled "Staff and
Facilities in the Basic Medical Sciences in Canadian
Medical Schools". This was prepared by the Faculty of
Medicine, University of Western Ontario under Dr. Warwick,



Stewart

the United States. In some ways we are closer to the
 British model. It has been suggested here that we
 should not do what has been done in the United Kingdom,
 the setting up of independent research centres. Dr.
 Stewart has suggested the reason for this. Such centres
 would have a tendency to drain off people from the
 universities where it is very badly needed. We must
 look to the universities to provide men who are doing
 to be the teachers in these new and expanding medical
 schools, in the basic science departments as well as
 on the clinical side, and the development of research
 in the universities rather than in separate centres is,
 I think, rather fundamentally important, and to do this
 a great deal more money is needed.

I would like to come back to this
 question of taxation, which seems to me to be relatively
 easily remedied. The hospitals across the country,
 if I am not mistaken, have been free from this burden
 of taxation on the research side. I can see no reason
 in fact on taxation why models adjoining these
 hospitals should not be treated similarly; and if grants
 are given for cancer and heart disease, then this amount
 should not be reduced by taxation.

DR. FETTERER: Mr. Chairman, members
 of the Commission, I wish to thank you for the opportunity
 of submitting exhibit A. It is entitled "Grant and
 facilities in the Basic Medical Sciences in Canadian
 Medical Schools". This was prepared by the Faculty of
 Medicine, University of Western Ontario under Dr. [Name]



1
2
3 and I read from the first page Introduction.

4 "The Basic Medical Sciences - those
5 disciplines which provide the foundation for the study
6 of clinical medicine - include Anatomy, Biochemistry,
7 Microbiology, Pathology, Pharmacology and Physiology.
8 These sciences are the major study of the student in
9 the first two years of the four year medical course."

10 Then the last paragraph under
11 Introduction:

12 "In preparing this report a questionnaire
13 was sent to the Deans of the twelve Canadian Medical
14 Schools to obtain information on the personnel, space
15 and facilities that exist at present and some responsible
16 opinion on what degree of expansion is necessary to
17 maintain and improve the Basic Medical Sciences in
18 Canada. Certain comparisons with the situation in the
19 United States are drawn because its system of medical
20 education is similar to ours and the working conditions
21 in their medical schools are attracting our medical
22 scientists in every greater numbers."

23 These comparisons are prepared or at
24 least are based on a document which was prepared under
25 the United States Department of Health and Welfare which
26 studies the medical school facilities, including
27 personnel necessary to carry on medical education, and
28 the exhibit which I submit to you, sir, has four
29 appendices which are the sum of accumulation of statistics
30 from the Deans of the medical schools in support of
the conclusions and recommendations which you find on
page 6 of the exhibit.



and I read from the first page of the report.

"The Basic Medical Sciences - those

disciplines which provide the foundation for the study of clinical medicine - include Anatomy, Biochemistry,

These sciences are the major study of the student in the first two years of the four year medical course."

Then the last paragraph under

Introduction:

"In preparing this report a questionnaire

was sent to the Deans of the twelve Canadian Medical

Schools to obtain information on the personnel, space

and facilities that exist at present and some responsible

opinion on what degree of expansion is necessary to

maintain and improve the Basic Medical Sciences in

Canada. Certain comparisons with the situation in the

United States are drawn because its system of medical

education is similar to ours and the working conditions

in their medical schools are attracting our medical

scientists in every greater numbers."

These comparisons are prepared on at

least are based on a document which was prepared under

the United States Department of Health and Welfare which

studies the medical school facilities, including

personnel necessary to carry on medical education, and

the exhibit which I submit to you, sir, has four

appendices which are the sum of accumulation of statistics

from the Deans of the medical schools in support of

the conclusions and recommendations which you find on

page 6 of the exhibit.



Ettinger

9803

I read now page 6; Conclusions and Recommendations.

"Problems of the utmost urgency exist in the Basic Medical Science Departments of Canadian Medical Schools.

1. At present, the Basic Medical Science Departments are inadequately staffed. The need in Canada as a whole, at present, has been estimated as being at least 410, which represents an increase of 134 over the existing number. If the present staff is to be retained, and able people are to be attracted to the Basic Medical Sciences, it is necessary to provide higher salaries. Such salaries should be commensurate with the earning capabilities of men and women of comparable ability who choose to follow different careers. An increase in present salaries of some 20 to 25 percent, depending upon rank, has been recommended. These recommended increased will need to be reviewed in the light of changing economic conditions.

2. The Basic Medical Science Departments have inadequate space for their present responsibilities in teaching and research. An overall increase of 33 percent is needed to meet the recommended standards for medical schools.

3. From a practical standpoint, the deficiencies described can be all corrected by additional funds. It is essential that such funds should be made available to the Faculties of Medicine as education grants."

Thank you.

COMMISSIONER FIRESTONE: Dr. Stewart,

I read now page 6, Conclusions and

proposals of the utmost urgency exist
in the Basic Medical Science Departments of Canadian
Medical Schools.

2. The Basic Medical Science Departments
are inadequately staffed. The need in Canada as a whole
at present, has been estimated as being at least 40%
which represents an increase of 134 over the existing
number. If the present staff is to be retained, and some
of the staff to be attracted to the Basic Medical Sciences,
it is necessary to provide higher salaries. Such
salaries should be commensurate with the training
and experience of men and women of comparable ability who
choose to follow different careers. An increase in
present salaries of 20 to 25 percent, depending
on rank, has been recommended. These recommended
increases will need to be reviewed in the light of
changing economic conditions.

3. The Basic Medical Science Departments
have inadequate space for their present responsibilities
in teaching and research. An overall increase of 33
percent is needed to meet the recommended standards for
Medical Schools.

4. From a practical standpoint, the
proposals outlined can be all but met by additional
funds. It is essential that such funds should be made
available to the faculties of Medicine as education

ends." Thank you.



Stewart

9804

1
2
3
4 you mentioned at the beginning of your comments that
5 there is a change of the number of students entering
6 the field of medicine, and you referred to both increasing
7 numbers as well as improvement in quality. Can you
8 give us you explanations of the reason for this change
9 that seems to be taking place?

10 DR. STEWART: I think, Mr. Chairman,
11 Mr. Firestone, that our medical educators and the
12 medical profession were perhaps a little unduly worried
13 about the trend which showed up after peak of the
14 veteran classes through medical schools. We had from
15 a period of 1945 to 1950 practically no veterans
16 admitted to medical schools. For a short time thereafter
17 we had a very brilliant group of young men and the
18 selection was pretty thick and we could take the cream.
19 A few articles were written, on in particular in the
20 Journal of Medical Education about 1956, indicating
21 that the proportion of students in the (a) based on
22 pre-medical standing was 36% in 1950, 1951, I believe,
23 and it fell sharply to about 16%, 18% and remained at that
24 level, and the assumption made by the writer was that
25 we were getting half as good men in medicine as we
26 used to. In fact, it was based on a most abnormal year
27 in which there were perhaps twice as many brilliant men,
28 and I never did believe that there was a decrease in
29 the quality of men going into medicine. I think it
30 all comes back to that article, and I think it is even
more indicated that this trend has been reversed.

As far as the numbers are concerned,
there was a falling off after the veteran intake and



...mentioned at the beginning of your comments that
there is a change of the number of students entering
the field of medicine, and you referred to both increasing
numbers as well as improvement in quality. Can you
give us your explanations of the reason for this of the
that seems to be taking place?

Dr. Winesburg, that our medical educators and the
medical profession were perhaps a little more worried
about the trend which showed an after peak of the
veteran classes through medical schools. We had from
a period of 1945 to 1955 practically no veterans
admitted to medical schools. For a short time there was
a very brilliant group of young men and the
situation was pretty thick and we could make the error.
A lot of articles were written, on in particular in the
Journal of Medical Education about 1955, indicating
that the proportion of students in the (a) passed on
pre-medical standing was 66% in 1950, 1951, I believe,
and it fell sharply to about 19%, 19% and remained at that
level, and the assumption made by the writer was that
we were getting half as good men in medicine as we
used to. In fact, it was based on a most abnormal year
in which there were perhaps twice as many brilliant men,
and I never did believe that there was a decrease in
the quality of men going into medicine. I think it
all comes back to that article, and I think it is even
more important that this trend has been reversed.
As far as the numbers are concerned,
there was a falling out after the veteran influx and



Stewart

9805

1
2
3
4 the younger people who had not had military service,
5 and from about 1953 or 1954 to 1957 or 1958 there was
6 quite a marked fall. Since that time it has been going
7 up, and I think it is parallel with the general increase
8 in university population in most parts of Canada but
9 later by about three years than other universities because
we require three or four years pre-med education.

10 COMMISSIONER FIRESTONE: On this
11 question of quality, would you say that one of the factors
12 might be that quality of general education in the pre-med
13 years has been raised, the standards have been raised,
14 and that would affect the quality of people who would
15 then apply to enter medicine? Has there not been a
16 tightening of standards in most universities, throughout
the years?

17 DR. STEWART: I think this is true,
18 sir.

19 COMMISSIONER FIRESTONE: And this would
20 affect the quality of students entering medicine?

21 DR. STEWART: It would naturally do so,
22 yes.

23 COMMISSIONER FIRESTONE: On the question
24 of numbers, we have heard about the large bulge of young
25 people expected to enter universities and then they
26 become eligible to take up medicine. Would you feel that
27 with this large bulge of students expected to enter
28 the universities generally medicine will get its proper
share or perhaps its proportion to the total would
increase?

29 DR. STEWART: It is a little difficult
30



1931

the younger people who are not doing military service,
 and from about 1913 or 1914 to 1917 or 1918 there was
 quite a marked fall. Since that time it has been going
 up, and I think it is parallel with the general increase
 in university education in most parts of Canada. But
 later by about three years than other universities. I think
 we require three or four years' professional education.

COMMISSIONER FIRESTONE: On this

question of quality, would you say that one of the factors
 might be that quality of general education in the sciences
 years has been raised, the standards have been raised,
 and that would affect the quality of people who would
 then apply to enter medicine? Has there not been a
 tightening of standards in most universities, throughout
 the country?

MR. STANLEY: I think this is true.

air.

COMMISSIONER FIRESTONE: And this would

affect the quality of students entering medicine?

MR. STANLEY: It would naturally do so.

COMMISSIONER FIRESTONE: On the question

of numbers, we have heard about the large bulge of young
 people expected to enter universities and then they
 become eligible to take up medicine. Would you feel that
 with this large bulge of students expected to enter
 the universities generally medicine will get its proper
 share or perhaps its proportion to the total would

MR. STANLEY: It is a little difficult



Stewart

9806

1
2
3
4 to say that yet, sir, because the increase has been
5 only over a period of about three years and it is
6 hard to say whether we are getting the same proportion.
7 My impression is in our own area that the increase in
8 university intake and the increase in medical schools
9 over this period are approximately parallel. But I
10 don't think we really have enough data upon which to
11 judge this. I would point out, however, that the increase
12 has been such in the last few years that practically
13 every medical school will have reached its full quota
14 of students, and no matter how many students apply in
15 the next few years for entry to medical schools, they
16 will not get in unless there is an increase in facilities,
17 and I think this is a sad situation, that we will have
18 a highly qualified student wanting to learn medicine
19 and we have to turn them away.

20 COMMISSIONER FIRESTONE: Would you
21 say that there is some urgency for the recommendation
22 you have made for the expansion of facilities?

23 DR. STEWART: Tremendous urgency, sir.
24 I think there is a top priority both as far as the
25 development of more medical schools and existing medical
26 schools are concerned, and I would emphasize that this
27 not only pertains to increase in teaching facilities but
28 increase in research facilities, because we simply
29 cannot get the staff to teach these people until we
30 get facilities to teach these people in medicine and
in their other scholarly pursuits.



to say that yes, sir, because the increase has been only over a period of about three years and it is hard to say whether we are getting the same proportion. My impression is in our own area that the increase in university intake and the increase in medical schools over this period are approximately parallel. But I don't think we really have enough data upon which to judge this. I would point out, however, that the increase has been such in the last few years that practically every medical school will have reached its full quota of students, and no matter how many students apply in the next few years for entry to medical schools, they will not get in unless there is an increase in facilities and I think this is a sad situation, that we will have a highly qualified student wanting to learn medicine and we have to turn them away.

COMMISSIONER FIRESTONE: Would you say that there is some urgency for the recommendation you have made for the expansion of facilities?

I think there is a top priority both as far as the development of more medical schools and existing medical schools are concerned. and I would emphasize that this not only pertains to increase in teaching facilities but increase in research facilities, because we simply cannot get the staff to teach these people until we get facilities to teach these people in medicine and in their other scholarly pursuits.



Stewart

COMMISSIONER FIRESTONE: That is a very constructive suggestion, thank you very much. You have in paragraph S2 a recommendation that there be no reduction in the total duration of undergraduate studies. Have you any views about medical students taking summer courses?

DR. STEWART: One of the suggestions which we mention in the body of the report is that if students did not have to earn part of the cost of their medical education during the summer it may be possible for the course to be, not shortened in the effective teaching period, but shortened in the number of calendar years that the student may have to have. There are several requirements: one, that there be enough support for students that they do not have to earn money during the summer to pay for their education which means a very large increase in grants to students.

Secondly, that there be at least a 33% increase in the staff so that the staff who are now teaching nine months of the year would still have that additional three months for their research.

COMMISSIONER FIRESTONE: That, of course, assumes that every student would take a summer course but you do not expect that; there may be some that will and some will not so you may not quite require a one-third increase in the teaching staff. Perhaps a smaller increase might achieve the objective but certainly there will be an increase required.

DR. STEWART: I would hesitate to believe that this was feasible. In other words, that we

COMMISSIONER: That is a

very constructive suggestion, thank you very much.

You have in paragraph 22 a recommendation that there be no reduction in the total duration of undergraduate studies. Have you any views about medical students

17. STEWART: One of the suggestions

which we mention in the body of the report is that if students did not have to earn part of the cost of their medical education during the summer it may be possible for the course to be, not shortened, in the effective

teaching period, but shortened in the number of calendar

years that the student may have to have. There are

several requirements: one, that there be enough support

for students that they do not have to earn money during

the summer to pay for their education which means a very

large increase in grants to students.

Secondly, that there be at least a

13% increase in the staff so that the staff who are

now teaching nine months of the year would still have

that additional three months for their research.

COMMISSIONER: That, of

course, assumes that every student would take a summer

course but you do not expect that; there may be some

that will and some will not so you may not quite require

a one-third increase in the teaching staff. Perhaps

a smaller increase might achieve the objective but

certainly there will be an increase required.

OK. STEWART: I would hesitate to

believe that this was feasible. In other words, that we



Stewart

9808

would be running - a medical school is operated with a program for a year in which all students are participating and travelling at the same rate. If I may say so, if you added an additional two or three months in the summer for some students it would mean we would have to duplicate practically our whole program because we would have some students out of step, a little further ahead than the others. My own personal view, and this has never been discussed in the Association as a whole, would be that the year would have to be lengthened for all students in order for it to be a satisfactory arrangement. Perhaps the other Deans who are here may comment on that; I do not know what their views might be.

DR. STEVENSON: Well, as Dr. Stewart knows, this has been done in both ways in some of the schools in the United States and I think those of us who have seen the kind of program where you have students out of phase, if I may use this expression, find the result deplorable.

In other places, the term for students has been lengthened to 45 weeks and I think this can well be done if, as Dr. Stewart has remarked, the students were supported, were given additional help so they would not have to earn part of the costs in the summer and if the staff was increased so this would not be done at the expense of research.

COMMISSIONER FIRESTONE: That is a very fair proposal. My main question really is whether one would necessarily have to extend the academic year to



would be running - a medical school is operating on
a program for a year in which all students are practicing
eating and travelling at the same rate. If I run a
school, if you start an additional two or three months in
the summer for some student it would mean we would
have to duplicate practically our whole program because

we would have some students out of step, a little
further ahead than the others. My own personal view,
and this has never been discussed in the Association
as a whole, would be that the year would have to be
lengthened for all students in order for it to be a
satisfactory arrangement. Perhaps the other people
who are here may comment on that; I do not know what
their views might be.

MR. STEVENSON: Well, as Mr. Stewart

knows, this has been done in both ways in some of the
schools in the United States and I think those of us
who have seen the kind of program where you have students
out of phase, if I may use this expression, find the
result negligible.

In other places, the term for students
has been lengthened to 48 weeks and I think this has
well be done it, as Mr. Stewart has remarked, the students
are so tired, when given additional help so that
would not have to earn part of the costs in the summer
and if the staff was increased so this would not be
done at the expense of research.

COMMITTEE FIRST: That is a very

fair proposal. My main reaction is rather one
well, we really have to extend the academic year.



Stevenson

9809

1
2
3
4 12 months or 11 months, as the case may be, to all
5 students or whether some can follow the existing pattern
6 and some that are in a hurry could follow a speed-up
7 course. The effect may be that those who are in a hurry
8 could finish in four years or four-and-a-quarter years
9 instead of five years. Perhaps it would not be necessary
10 to do this at every university, possibly at one or other
11 university. This is really the question, I would not
12 want to suggest or imply that with my question you want
13 every student to work the full year if he does not wish
14 to do so but would the other system be practical?

15 DR. STEVENSON: As I intended to suggest,
16 it is being tried out, for instance, in Tennessee and
17 those of us who have seen it think that the result is
18 chaos. Neither can it be done in one or two schools
19 and students from other schools to go there in order to
20 be far enough ahead because there is enough difference
21 in the curriculum that this would not be possible. If
22 things were being run in this way the medical school
23 would, in effect, be running two medical courses at the
24 same time and this would multiply the timetable and the
25 teaching load would result, as we have seen it, in a
26 very unsatisfactory set-up.

27 I think the choice would be to leave
28 things as they are in this respect or to lengthen the
29 year and so shorten the total course for all students.

30 Again, I would say I would hope that
this would not be contemplated unless proportionate
increases in staff would be made.

DR. STEWART: If I may say one thing:

12 months or 18 months, as the case may be, to all
 students or whether some can follow the existing program
 and some that are in a hurry could follow a condensed
 course. The idea of having those who are in a hurry
 could finish in four years or four-and-a-half years
 instead of five years. Perhaps it would not be necessary
 to do this at every university, possibly at one or other
 university. This is really the question, I would not
 want to suggest or imply that with my question you want
 every student to work the full year if he does not wish
 to do so but would the other system be practical?

Dr. STEVENSON: As I intended to suggest,
 it is being tried out, for instance, in Tennessee and
 those of us who have seen it think that the result is
 good. Neither can it be done in one or two schools
 and students from other schools to go there in order to
 be far enough ahead because there is enough difference
 in the curriculum that this would not be possible. If
 things were being run in this way the medical school
 would, in effect, be running two medical courses at the
 same time and this would multiply the timetable and the
 teaching load would result, as we have seen it, in a

I think the choice would be to leave
 things as they are in this respect or to lengthen the
 year and so shorten the total course for all students.
 Again, I would say I would like to see
 this would not be contemplated unless proportionate
 increases in staff would be made.
 Dr. STEVENSON: If I may say one thing:



Stewart

9810

however, I think Dean Stevenson has said it really but to look at it another way, if you had one-third of the class go in for the summer months at the beginning of the next term you would have, in effect, two - three classes and you would need about two staffs of teachers to take care of the two classes.

If the whole group were changed over to a new schedule, to a longer year, you could probably get by with about one-third increase in staff. I think it would be more economic to do it for all than for a small group.

COMMISSIONER BALTZAN: Then you would have the annual summer ebb in hospital patients which greatly impedes teaching?

DR. STEVENSON: This would create a difficulty. In many centres there is a very substantial falling off of hospital population during summer months.

COMMISSIONER FIRESTONE: Thank you for your comments, gentlemen.

COMMISSIONER VAN WART: Is there not a danger in the lengthened year of the student getting stale after the three years, one right after another with a very small vacation?

DR. STEWART: I think this is something that would have to be considered. As we have said in our brief, we are not recommending this, we are just suggesting that very careful study be given to it. You have presented one of the pawns; we have been presenting some of the favourite things.

DR. ETTINGER: May I speak to that

however, I think Dean Stevenson has said it really did
to look at it another way, if you had one-third of the
class go in for the summer months at the beginning of
the next term you would have, in effect, two - three
classes and you would need about two staffs of research
to take care of the two classes.

If the whole group were charged over
to a new schedule, to a longer year, you could probably
get by with about one-third increase in staff. I think
it would be more economic to do it for all than for a
small group.

COMMISSIONER SULLIVAN: Then you would
have the annual summer gap in hospital patients which
greatly impedes teaching?

DR. STEVENSON: This would create a
difficulty. In many centres there is a very substantial
falling off of hospital population during summer months.
COMMISSIONER FIKESBORO: Thank you for

COMMISSIONER VAN WART: Is there not a
danger in the lengthened year of the student getting
stale after the three years, one right after another
with a very small vacation?

DR. STEWART: I think this is something
that would have to be considered. As we have said in our
paper, we are not recommending this, we are just suggest-
ing that you consider study be given to it. You have
presented one of the papers; we have been presenting
some of the favorable things.

DR. STEWART: May I speak to that



Ettinger

9811

question? I am not sympathetic to this view because I see schoolteachers coming to summer school and having only two or three weeks left of their vacation. Working intensely at summer school after working all year at teaching. I see high school students starting at the 1st of September; these are younger students than our university students, to continue their studies until the end of June. I do not think our graduates from high school are less mature than those who have had previously longer period of education. I think if they are serious they can create interest.

COMMISSIONER FIRESTONE: That is very helpful, sir. May I now turn to Recommendation S12 on page II in which you say, and I quote:

"That the Canadian universities assume a greater responsibility in graduate training, and that funds be provided for them to employ the number of specially qualified teachers, necessary to organize and direct the program."

Your suggestion here is that funds be provided; where would those funds come from?

DR. STEWART: I think most of the recommendations we have made, we are thinking of Federal Government funds. The Provincial Governments are doing a good deal in medical education in most centres and a few of the medical schools are wholly provincially-financed. Perhaps the three of us here represent, I think, almost the only three that are not in that



question? I am not sympathetic to this view because

I see school teachers coming to summer school and

having only two or three weeks left of their vacation.

Working intensely at summer school after working all

year is tiring. I see high school students starting

at the last of September; these are younger students than

our university students, to continue their studies until

the end of June. I do not think our graduates from

high school are less mature than those who have had

previously longer periods of education. I think if they

are serious they can create interest.

GOVERNMENT RESPONSIBILITY: That is very

misleading, sir. May I now turn to recommendation 22 on

page 11 in which you say, and I quote:

"That the Canadian universities

assume a greater responsibility in

graduate training, and that funds

be provided for them to employ the

number of specially qualified

teachers necessary to organize and

direct the program."

The suggestion here is that funds be

provided; where would these funds come from?

MR. SHAW: I think most of the money

mentioned we have made, we are thinking of Federal

Government funds. The Provincial Governments are joining

a great deal in medical education in most provinces and a

few of the medical schools are wholly provincially-



Stewart

9812

fortunate category and have to depend a good deal more upon endowment funds for our own institutions.

COMMISSIONER FIRESTONE: You are quite right, you have made a number of recommendations for increased grants of financial assistance. In some instances you have spelled this out and you have now clearly stated that you would expect that to be forthcoming from the Federal Government. Would it be possible for you and your associates, Dr. Stewart, to have some figures to substantiate some of those or make more specific those recommendations which are included in here. When you speak of funds being provided, how much do you mean by "funds"? In some other cases, you speak of appropriate stipends or adequate resources; what is the appropriate amount of the funds to be provided?

In other words, it would help us a great deal if we had specific proposals for so-and-so many grants for such-and-such amounts to be given to these people for this purpose and add this thing up and then you would see the total grants given under X millions.

On this basis it would be doubling or tripling and then you may further wish to come and say that this is an initial program where, over a period of time, we would suggest the program would expand as our requirements expand.

In other words, you are not just giving us an answer to deal with the problem as it exists today but something that will help you develop a program of research and teaching and training over the next 10



1942 Stewart

fortunate category and have to report a great deal more
your enjoyment under your own institution.

CONSTITUTIONAL QUESTIONS: You are quite

right, you have made a number of recommendations for

increased grants of financial assistance. In some

instances you have spelled this out and you have not

clearly stated that you would expect that to be forth-

coming from the Federal Government. Would it be possible

for you and your associates, Dr. Stewart, to have some

figures to substantiate some of those or make more

specific those recommendations which are included in

them. When you speak of funds being provided, how much

do you mean by "large"? In some other cases, you speak

of appropriate amounts or adequate resources; what is

the appropriate amount of the funds to be provided

in other words, it would help us a

great deal if we had specific proposals for so-and-so

many grants for such-and-such amounts to be given to

these people for this purpose and add this thing up and

then you would see the total grants given under X

On this basis it would be desirable to

thinking and then you may further wish to come and say

that this is an initial program where, over a period of

time, we would suggest the program would expand as our

requirements expand.

In other words, you are not just giving

an answer to deal with the problem as it exists

today but something that will help you develop a program

of research and training and creating over the next 10



Stewart

9813

years. This may be asking a little too much and if it is, please say so but that is the sort of thing in complete terms that would translate your recommendations in very specific terms which would go beyond the terms of the Farquharson Report.

DR. STEWART: I think this is a reasonable request and we have done some work on this since the brief was prepared. We would be prepared to send into you a more formal statement along this line. Roughly, the figures are of some shocking level, I suppose, but the recommendations we have made might add up to an annual amount of approximately \$60,000,000 and a capital amount of \$100,000,000 to \$120,000,000. We can document that item by item.

COMMISSIONER FIRESTONE: You are reading my mind. If this can be documented program by program, purpose for purpose and the reasons for it and the results that you expect to achieve from this program, this would be particularly helpful and perhaps such a documentation could be made available to us by sending it to our Secretary in the next several months. This would be very helpful and we would hope it would communicate your ideas to Dr. MacFarland, who, as you know, is engaged in studies of advice to offer to the Commission.

We would, in turn, rely on Dr. MacFarland and his associates for their advice as to the appropriateness of some of the recommendations you may be making. Thank you very much for your willingness to undertake this.



Stewart
9413

years. This may be asking a little too much and if it is, please say so but that is the sort of thing in complete terms that would translate your recommendations in very specific terms which would go beyond the terms of the Farquharson Report.

DR. STEWART: I think this is a reasonable

request and we have done some work on this since the brief was prepared. We would be prepared to send into you a more formal statement along this line. Roughly, the figures are of some shocking level, I suppose, but the recommendations we have made might add up to an annual amount of approximately \$60,000,000 and a capital amount of \$100,000,000 to \$150,000,000. We can document that item by item.

COMMISSIONER FIRSTONE: You are

reading my mind. If this can be documented program by program, purpose for purpose and the reasons for it and the results that you expect to achieve from this program, this would be particularly helpful and perhaps such a documentation could be made available to us by sending it to our Secretary in the next several months. This would be very helpful and we would hope it would communicate your ideas to Dr. MacFarland, who, as you know, is engaged in studies of advice to offer to the

we would, in turn, rely on Dr. MacFarland and his associates for their advice as to the appropriateness of some of the recommendations you may be making. Thank you very much for your willingness to undertake



COMMISSIONER BALTZAN: Gentlemen,

I am sure your documents will be most valuable to the Committee on Medical Education. I want to perhaps just raise a few points, not exactly in the form of questions. First, with our existing medical schools, and take the largest of them, in the large schools, what is the most desirable number of students entering the first year?

DR. STEWART: I think I should ask the Dean of the largest school of the three represented here to express an opinion on that.

DR. STEVENSON: Well, there are a number of schools, Dr. Baltzan, and Mr. Chairman, in Canada in a range of the sixties. The largest school is Toronto and the next is McGill with approximately 100, I think a little over 100. I think the ideal school if this were the best of all possible worlds, would be smaller than this, because of the pressure to increase the production of doctors in the United States which is increasing from 75 to 90 or 95 -- I think this is already becoming too big. There are some centres where it is impossible to go beyond 65, 70, 75 because of the limitations of clinical facilities. You just can't teach properly if you haven't got enough teaching beds and enough people in out-patients. Where there are a sufficient number I think there is an over-limit for efficiency. It is generally agreed a hospital can become too large. I think this is also true of the medical school in that somewhere around 100 is probably the top limit where a first-rate job can be done. There are many good schools that run 150 and upwards, but it becomes increasingly difficult as the size increases



...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...



Stevenson 9815

to do a thoroughly good job.

COMMISSIONER BALTZAN: My question has been in relation to the problem of expansion of schools or building more schools. For these techniques you would be in favour of more schools rather than enlarging of schools in the existing areas except in the areas where there is only 60 allowed in the first year and sufficient population.

DR. STEVENSON: Correct.

COMMISSIONER BALTZAN: On Page 2, the Hospital Insurance Act be amended to recognize the teaching hospitals which shall have the obligation to establish teaching units in the interest of the universities. Do you imply, would you explain to me if it is intended to segregate the patients for the purpose of teaching? What do you mean by units?

DR. STEWART: Mr. Chairman, the Association of Canadian Medical Colleges and the Canadian Medical Association and the Royal College of Physicians and Surgeons have all agreed upon, I think, pretty much the same definition of a teaching unit. That is they consider it would be a group of beds geographically separated in which all of the patients would be under an active staff man, resident, interne, and a clinical clerk (undergraduate). This doesn't mean this would be the only area of the hospital in which teaching could be done. There would be and could be teaching on the private or semi-private patients with the approval of the doctor and of the patient and in other areas of the hospital, but in order to have an effective teaching program the nucleus



Stewart 9816

of a minimum of ten beds per senior student is required in a separate unit.

COMMISSIONER BALTZAN: Are you prompted to this sort of thinking because of the spread of prepaid services where patients have their own physicians more than ever before?

DR. STEWART: Yes, I think that this is an important factor that has to be considered, yes.

COMMISSIONER BALTZAN: But not to the exclusion of engaging good teaching material in the hospital outside of this.

DR. STEWART: Not at all, not excluding.

COMMISSIONER BALTZAN: What is the ratio of medical teachers to medical students for optimum requirements?

DR. STEWART: I think we have that, sir, in one of the appendices. I am afraid I don't remember the actual number. It is on Page 7, Appendix A, 6.5 is the number of students per teacher.

DR. ETTINGER: That is total teachers.

COMMISSIONER BALTZAN: We have only received this now.

DR. STEWART: Appendix A, Page 7, sir, it compares the figures for Canada and the United States in the smaller schools and the larger schools.

COMMISSIONER BALTZAN: Thank you. I shall look at that a little later. When you are speaking of post-graduate studies are you thinking in directions of continuation of studies at a higher level rather than perhaps looking forward to another institution or



Stewart 9817

national institution, post-graduate schools?

DR. STEWART: I don't recall that the Association of Canadian Medical Colleges has as an organization discussed this, sir, but I would express a personal opinion that such training is best in a hospital affiliated with a medical school where there are undergraduate students as well.

COMMISSIONER BALTZAN: Not separate entities?

DR. STEWART: Not separate entities for the training of specialists separately.

COMMISSIONER BALTZAN: Thank you. I look with pleasure at something on Page 22. I will just read one sentence:

"The university should be represented on the administrative board of the hospital; the university and the hospital should share responsibility for the nomination and appointment of physicians to the clinical staff of the hospitals:".

The reason why I brought this up is because we have a contrary opinion from two schools in two different provinces. This is a much broader approach. The terms they used, in order to have better control. This is a final opinion of the medical schools of Canada.

DR. STEWART: I am not sure, sir, what would have been meant by an order to have better control, but I think the arrangement is that the responsibility for selecting a person for an appointment in the clinical department is left generally to a small



1
2 group or individual and the university has a major role
3 in making selections. The appointment is approved, must
4 be approved by both the Board of Governors of the
5 University and the Board of Management of the Hospital,
6 or whatever the term may be in the particular institution.

7 COMMISSIONER BALTZAN: It is implied in
8 your submission it should be shared.

9 DR. STEWART: Yes, I think that is
10 correct.

11 COMMISSIONER BALTZAN: Finally, just
12 one thing: Having a course of instructions from clinical
13 researchers, but also teaching something of a formal
14 nature. I know many of us grew up self-made as to teach-
15 ing, thinking ahead, thinking in terms also of teachers
16 to be instructed and methodology of teaching is very
17 important.

18 DR. STEWART: I think this is a very
19 interesting point, sir. When I was first appointed as
20 Professor at the University I made inquiries as to where
21 in North America I could get some knowledge of how one
22 became a medical teacher and the assumption seemed to be
23 there was no need to have any special instruction because
24 there was no place in North America one could get any
25 assistance in this matter. This is a big gap, and I
26 think it is not very well filled yet.

27 COMMISSIONER BALTZAN: Since you speak
28 of your personal experiences, I did consult some members
29 of the teaching profession in this regard.

30 DR. STEVENSON: May I say, sir, work
was started some years ago at the University of Buffalo
with reference to medical pedagogy. There is now a very
interesting program going forward at the University of



Stevenson 9819

Illinois, the largest medical school in the United States. They are interested in this because of the difficulties of running such a large medical school and what kind of teaching is going on. They have a very good program. The Medical College of Virginia also has a research program in medical education and methods of teaching. I hope in Canada, all Canadian schools will take advantage of this work and will also initiate something of this in Canada itself.

COMMISSIONER BALTZAN: You are sort of throwing this out to all people that are listening here.

THE CHAIRMAN: Thank you very much, Dr. Stewart and gentlemen.

DR. STEWART: Thank you, sir.

THE SECRETARY: The next submission is of the Connaught Medical Research Laboratories of Toronto. Dr. Ferguson will make the presentation which will be known as Exhibit 268.



S U B M I S S I O N O F
CONNAUGHT MEDICAL LABORATORIES, TORONTO

---EXHIBIT NO. 268; Submission of the Connaught
Medical Laboratories, Toronto.

APPEARANCES:

DR. J.K. W. FERGUSON

THE CHAIRMAN: Dr. Ferguson, it is
unfortunate you come so late in the day.

DR. FERGUSON: I am at your disposal,
Mr. Chairman. May I sit down?

THE CHAIRMAN: Please do.

DR. FERGUSON: I take it that you wish
that I read the recommendations.

THE CHAIRMAN: You may make any obser-
vations you wish. I wouldn't want you to cut it down too
much, because this is an important aspect of research
work.

DR. FERGUSON: I think I should say,
Mr. Chairman, that I do not consider this presentation
as one on behalf of the Connaught Medical Research Labora-
tories. The Connaught Medical Research Laboratories have
been a self-supporting part of the University of Toronto
for 47 years, and if they cannot get along with the
experience they have acquired in making a living this
way, I wouldn't want to be a Director.

I feel my presentation is more a matter
of stating some opinions which I acquired as a result of
my experience as a Director and as Professor of Pharma-
cology for nearly two decades before that. I will read



THE UNIVERSITY OF CHICAGO

DEPARTMENT OF THE HISTORY OF ARTS

CHICAGO, ILL. 60637

Dear Mr. [Name]

I am very pleased to hear from you.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.



Ferguson 9821

the recommendations.

1. It is recommended that each province be requested to present as a separate part of its submission to the Royal Commission, a description of the procedures employed to select, procure, and distribute drugs for its public health services.

2. It is recommended that the Commission have the presentations analyzed and compared, because they represent procedures which have been tested in practice and may well be applicable to the provision of drugs for more comprehensive personal medical care plans.

This is another set of recommendations directed to hypothetical considerations of more extensive medical care insurance plans.

Recommendations for the provision
of drugs under medical care insurance plans

1. A medical care insurance plan should include the issue, without charge of some drugs, but not of all drugs.

2. Drug benefits should be started by providing only the more expensive drugs needed for long periods. The scope of the service can be enlarged gradually after methods of control have been developed.

3. The drugs to be provided should be selected on the advice of committees or panels of medical scientists. If the cost of the drug benefits is to be paid by the Federal Government, the panels or committees should be

1.

It is recommended that each province be
permitted to present as a separate part of its
submission to the Royal Commission, a descrip-
tion of the procedure employed to select,
and, if desired, the names for its sub-
committee.

2.

It is recommended that the Commission have
the procedures analyzed and compared,
because they represent procedures which have
been tested in practice and may well be
applicable to the provision of drugs for more
comprehensive personal medical care.

3.

This is another set of recommendations
pertaining to the medical care insurance plan.
of more extensive medical care insurance plan.

4.

A medical care insurance plan should include
the issue, without charge of some drugs, but
not of all drugs.

5.

Long term benefits should be stated by providing
only the more expensive drugs needed for long
periods. The scope of the service can be
enlarged gradually after methods of control

6.

The drugs to be provided should be selected
on the basis of committee or panels of
medical specialists. If the cost of the
drug benefits is to be paid by the federal
Government, the panels or committees should be



Ferguson

9822

established and coordinated by the Medical
Research Council of Canada.

4. The drugs should be purchased by a government
agency. If the cost is borne by the Federal
Government, a federal agency should do the
purchasing. If the costs are shared with the
Provincial governments, the provincial
governments should do the purchasing.

5. The drugs should be issued from government
depots directly to the user; doctors, nurses,
or patients as the case may be.

DR. FERGUSON: Now, Mr. Chairman,
whether you wish me to read the rest I leave to your dis-
cretion.

THE CHAIRMAN: I think it would be
desirable.

DR. FERGUSON: I would be happy to
do so.



1917

1917

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

MR. FREDERICK: Now, Mr. Chairman,

whether or not we are to have the rest of the year to come...

MR. CHAIRMAN: I think it would be...

MR. FREDERICK: I would be happy to...

...



Ferguson

9823

The Provision of Drugs by the Public Health Services
of Canada

This submission presents an outline of the methods employed over a period of years in Canada by which drugs used in public health programs of preventive medicine have been selected, procured, and distributed. A forecast is made of the changes which may be expected in these operations assuming that present forms of organization are continued and present trends prevail. It is suggested that the procedures evolved for furnishing drugs for programs of public health may be applicable to the provision of drugs for the larger operations of personal medical services.

For many years all provinces in Canada have bought and issued, without charge, the medicinal preparations required for approved programs of preventive medicine. The preparations supplied are mostly vaccines and serums but also include antibiotics and other anti-infective drugs which may be used, for example, for the prevention of recurrent attacks of rheumatic fever or for the control of venereal disease. The drugs may be administered by a private practitioner or by a doctor or nurse in the public health services.

The cost of the drugs used each year in Canada for approved programs of preventive medicine is not great. Exact figures are not readily available but the total probably does not exceed \$3,000,000 a year or about 20¢ per person per year.

I might say that this figure was checked with the Deputy Minister of Health who thought



This information presents an outline of the methods employed over a period of years in Canada by which drugs used in public health programs of preventive medicine have been selected, procured, and distributed. A large part is made of the changes which may be expected in these operations assuming that present forms of organization are continued and present trends prevail. It is suggested that the procedures evolved for furnishing these for programs of public health may be applicable to the provision of drugs for the larger operations of general medical services.

For many years all provinces in Canada have bought and issued, without charge, the medicinal preparations required for approved programs of preventive medicine. The quantities applied are mostly vaccines and sera, but also include antibiotics and other anti-infective drugs which may be used, for example, for the prevention of recurrent attacks of rheumatic fever or for the control of venereal diseases. The drugs may be administered by a private practitioner or by a doctor in charge of the public health services.

The cost of the drugs used each year in Canada for approved programs of preventive medicine is not great. These figures are not readily available but the total probably does not exceed \$3,000,000 a year or about 10¢ per person per year.

I might say that this figure was

compiled with the Federal Minister of Health and through



Ferguson

9824

that it was a good guess.

THE CHAIRMAN: These are your public programs?

DR. FERGUSON: Yes.

THE CHAIRMAN: Thank you.

COMMISSIONER VAN WART: That is the Federal Deputy Minister or the Provincial?

DR. FERGUSON: Provincial.

The funds have been provided for the most part by the provincial governments, but in recent years the Federal Government has contributed by means of a system of health grants.

A large proportion of the serums and vaccines used by the provinces in their health programs are supplied by the Connaught Medical Research Laboratories and by the Institute of Microbiology of the University of Montreal which is a similar organization.

The Connaught Laboratories were established in 1914 as a non-profit enterprise controlled by the University of Toronto to conduct medical research and to supply the vaccines and serums needed by the public health departments of Canada. The relation of the Connaught Laboratories to the various governments of Canada in strictly formal terms is merely that of a supplier who must satisfy most of his customers most of the time or lose their business. In practice a much more complex and meaningful relationship has developed. It might be called a voluntary alliance for a common purpose, namely public health. Such a loose alliance might well have resulted in chaos. It has worked well



Ferguson

9825

for more than forty years, for two reasons. (1) Coordination of the policies of the provincial departments of health has been accomplished in a voluntary way for many years by the Dominion Council of Health. (2) The Connaught Laboratories through medical research and close association with the School of Hygiene of the University of Toronto have exercised acceptable scientific leadership in the field of immunology.

This can also be said of the Institute of Microbiology of the University of Montreal.

They have been able to offer for use in Canada important new biologicals designed to meet Canadian needs. They often succeeded in making new developments available for use in Canada before they were generally available in most other countries. The staff of the Connaught Laboratories and of the Institute of Microbiology included scientists of international repute who commanded respect as mentors in important fields of public health.

The provision of drugs for public health services is, with a few exceptions, entirely a responsibility of the provincial governments. However, in many instances the Federal Government has exerted some influence because, (1) the Deputy Minister of National Health presides at the semi-annual meetings of the Dominion Council and (2) National Health Grants support a number of the provincial programs.

The decisions of each province are usually made after the meetings of the Dominion Council of Health at which medical scientists in government



Ferguson

9826

1
2
3 service and independent experts give their opinions.
4 Each province is free to reject or to adopt the consensus
5 of the Council. The result has been to favour conserva-
6 tive decisions, not unduly influenced by commercial
7 promotion or the persuasion of patients to which private
8 doctors are so often subjected. Conservative is not
9 meant to imply long delays in the acceptance of new
10 preparations. Salk vaccine was accepted as fast as it
11 could be supplied, because the scientific evidence to
12 support its use was excellent.

13 The procurement of the drugs selected
14 is done by the purchasing agency of each provincial
15 Department of Health, sometimes by competitive tender
16 when there is a choice of suppliers. The prices paid
17 are often lower than those paid even by large public
18 hospitals. In some cases, however, sources of supply
19 are limited and are designated by the provincial health
20 department.

21 The drugs are stored in provincial
22 depots and issued on requisition by the physicians who
23 are entitled to use them. In many provinces physicians
24 in private practice are entitled and encouraged to use
25 all vaccines and serums as required for their patients.
26 Expensive items in short supply may be restricted to
27 certain classes of patient; for example, gamma globulin
28 may be given free to pregnant women exposed to german
29 measles or to persons exposed to infectious hepatitis.
30 Other patients may have to pay. Some drugs may be
distributed without charge only through mental hospitals,
or special clinics, or on requisitions approved by



Ferguson

9827

welfare services. The regulations governing the free issue of drugs vary among the provinces. It is suggested that the Commission should request from each province a separate report on their various methods of procuring and distributing drugs. A tabular comparison would reveal many similarities as well as many differences, and might provide useful suggestions based on experience for an expanded service. Without this information at his disposal the writer infers from his own observations that the following principles do for the most part govern the provision of drugs by the public health departments:

(1) The preparations and dosage forms provided are restricted to a list of important drugs selected after consultation with competent medical scientists, and discussion in the Dominion Council of Health.

(2) Purchasing is done in large lots at minimum prices through government agencies, for storage in government depots.

(3) Distribution is made directly to the doctor or nurse who administers the drug, and in some cases where the drug is used by the patient for long periods, directly to the patient.

(4) A large sector, even of preventive medicine, is left to private enterprise. This includes vaccines for mumps,



Ferguson

9828

influenza, common colds, boils and
hayfever. In general, preparations
which may have only small advantages
over standard products, or which may
be only partly effective, or dangerous
in some cases, or for ailments which
are not disabling, or preparations
which are very new and not fully
assessed, are left for private use or
organized research to establish their
value.

The free market for drugs is not
unregulated. The Food and Drug Directorate of the
Department of National Health has the authority to
restrict the sale of drugs which are dangerous and to
protect the public from fraudulent claims.

Predictions and Proposals

It is almost certain that expenditures
for vaccines and other preventive medicinals will
increase in the years to come. New vaccines, effective
against more diseases, are being developed. Measles
and infectious hepatitis may be the next diseases to be
controlled by vaccines. As new preparations become
available, they will be evaluated by the various agencies
of medical science for their safety and efficacy and for
their importance in contributing to the health of the
people. In due course (and sometimes very quickly when
the evidence is convincing) the important ones will be
put on the free list. When the evidence is uncertain
or the advantages questionable the dubious items will be



Ferguson

9829

left in the sector of private enterprise. A free market in which true value can be assessed by long experience is an asset which should be preserved.

It is suggested that the service most needed now to reduce the burdensome cost of medication is a more comprehensive plan to supply expensive drugs to those who need them for long periods after leaving hospital or for those who may never need to go to hospital. Drugs needed to treat acute illnesses in hospital are now provided through the hospital insurance plans operating in every province. The fear of crippling bills for drugs for acute illnesses has thus been removed to a large degree.

There are many persons who require daily doses of certain drugs to keep reasonably well and active. Diabetics who require insulin are in this class. Most diabetics spend no more than five or ten cents a day for insulin. In most provinces, it is felt that only indigents should get it free. The newer insulin substitutes for oral use are considerably more expensive and might be provided for those who need them. The question of medical necessity for such patients is often troublesome. For some patients, these tablets are a dangerous luxury rather than a medical necessity. In some provinces, one or more medical referees are appointed to settle such questions.

Epileptics are another group of persons who can often be kept reasonably well and active by very inexpensive medication. Others need expensive anticonvulsants.



Ferguson

9830

Antituberculous drugs are needed for long period in some cases for prevention of infection in others to ward off relapse.

Arthritics may need mediation for months or years, and sometimes it is of the more expensive kinds.

Cases of mental illness may need the newer and more expensive tranquilizers for long periods.

It is suggested that the more important and expensive drugs of recognized value for prolonged illness should be supplied without charge, and should be purchased in volume by governments. Other drugs should be left for private purchase through the normal channels of trade.

Many more drugs are available to doctors and to the public, even limiting consideration to those used for preventive medicine, than have ever been issued free in Canada.

The list of drugs issued free in Canada has grown steadily since 1916. It is hard now to analyze and to express briefly the various motives and considerations which led to the addition of each of them to the free list. The list has grown with the growth of medical science and the growth of public confidence in medical opinion.

In looking at the list now, the only principle that is discernable seems to be that each item is endorsed by the best available medical opinion. Another factor which has certainly been in operation at all times has been a sense of priorities as to benefits



...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...

...the ... of ...



Ferguson

9831

which might be achieved with the resources of organization, manpower, and money available. The factors of public demand and public acceptance have always been important.

The change in public attitudes towards doctors, hospitals, and medical services generally has been enormous during the last four decades. Forty years ago a majority of persons felt that going to a hospital was a prelude to death. Now most people seem to feel that admission to hospital is an inalienable right which should, of course, be free!

The big question now, in relation to drugs, is which items in the rapidly growing list of those available should be supplied free, and which should be paid for by the user. Nations which have tried to pay out of public funds for any and all drugs which any doctor may be induced to prescribe have found themselves confronted with ever-increasing costs for benefits which are often dubious.

It should be remembered that drugs even when prescribed by doctors are not always necessary or even desirable in the view of the best available medical opinion. Medical opinion, however, can change very rapidly, as indeed it should, when new facts become available. Freedom to try new treatments is an important personal freedom which should be preserved. But the price of personal freedom should always be personal responsibility. Free spending at the expense of the taxpayer should always be restricted and controlled.

COMMISSIONER FIRESTONE: Dr. Ferguson,



Ferguson

9832

1
2
3 in your paragraph 1 on the second set of your recommen-
4 dations, you suggested a medical care insurance plan
5 should include the issue, without charge, of some drugs,
6 but not of all drugs.

7 Do you have in mind in this recommenda-
8 tion a prepayment plan for drugs?

9 DR. FERGUSON: Not really. There might
10 be an alternative, and I was very interested in the
11 alternative which, I presume, was proposed by the
12 Green Shield, that this method of more or less free
13 insurance for drug benefits, pharmaceutical benefits,
14 more or less private enterprise operations, could be
15 a pilot model, and the implication that once the situation
16 was well-clarified, the Government might sponsor certain
17 groups under this plan.

18 I was really thinking of a more directly
19 government-administered type.

20 COMMISSIONER FIRESTONE: Under your
21 suggestion as contained in paragraph 1, the State would
22 purchase the drugs which would be available out of
23 general revenue and would distribute the drugs which
24 you have selected in paragraph 2 of your recommendations
25 and distribute these drugs, without charge, to the
26 patient.

27 DR. FERGUSON: That was what I was
28 envisaging, yes.

29 COMMISSIONER FIRESTONE: You speak of
30 expanding this program, in paragraph 2, over a period
of time after controls have been developed. What
controls do you have in mind, sir?



Ferguson 9833

DR. FERGUSON: The controls, I think, are outlined in the next three recommendations. Controls on the selection, in particular. Controls on the purchasing and then there is another control which is not in the recommendations but which is implied in the rest of the submission which means that controls would be very important on diagnosis. That has been found necessary in the case where the Government issued drugs of prophylaxis of rheumatic fever.

COMMISSIONER FIRESTONE: Would you also wish to consider some controls from the point of view of avoiding misuse of the system from the point of view of the recipient of those drugs?

DR. FERGUSON: Yes, I think that is implied in the discussion there, particularly in relation to the expensive drugs which are very necessary to use in the treatment of diabetes; that control would not only be for safeguarding the public purse, but to make sure that the patient was getting the benefit.

COMMISSIONER FIRESTONE: Would you, for example, visualize as a possibility of this control system, to avoid abuses, to have, say, a participating payment on the part of the patient? I am thinking now of the second group of drugs which you say might be introduced into the scheme at a later stage.

DR. FERGUSON: I know that has been done elsewhere. I would not be prepared to make a suggestion on this point because I have not had an opportunity to study these systems.

COMMISSIONER FIRESTONE: Thank you very



Ferguson

9834

much, sir. May I now turn to paragraph 5 of your
recommendations in which you suggest, and I quote:

"The drugs should be issued from
government depots directly to the
user; doctors, nurses or patients,
as the case may be."



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

... to the ...
... in ...
... be issued ...
... of the ...
... day of ...



Ferguson

9835

You appreciate, sir, that, if I understand your proposal here correctly the State would have to collect taxes or some other means whereby the State would pay for those drugs. Now, these drugs are distributed now to people, they are either purchased in a retail pharmacy or they are made available in an out-patient clinic in a hospital, etcetera. So there are two cost figures involved as far as the economy is concerned. One is the cost to government in purchasing these drugs and distributing, which includes the cost of purchase plus the handling charges, and the second cost is the cost that the people of Canada now have to pay for in purchasing the drugs.

Would you feel that under your system there would be a considerable reduction as to the cost to the society as a whole in purchasing and distributing essential and required drugs?

DR. FERGUSON: I think there is very little doubt that for the selected and restricted list of drugs that are issued free the cost of procurement and distribution would be much less under a system of this kind than under, let's say, the ordinary retailing system.

COMMISSIONER FIRESTONE: In other words, Canada as a whole would benefit under this scheme through spending substantially smaller amounts on drugs for this purpose than it is doing now?

DR. FERGUSON: That is a very loaded question, because I am not at all prepared to admit that Canada as a whole would benefit by a great reduction



Ferguson

9836

1
2
3
4 in expenditure in drugs, because when that happens
5 a lot of Canadians go out of work and I am very acutely
6 conscious of that, too. But I am making recommendations
7 by which government costs would be kept as low as
8 possible. I think government has to realize that while
9 they may be economizing in one way, they may be putting
people out of work.

10 COMMISSIONER FIRESTONE: It is really
11 a question of the economic impact of your proposal
12 in paragraph 5. If I understand you correctly, I would
13 cost Canadians less under the system you propose than
they are paying now.

14 DR. FERGUSON: For these drugs on a
15 restricted list I think the cost to the taxpayer would
16 be less.

17 COMMISSIONER FIRESTONE: Would it be
18 considerably less?

19 DR. FERGUSON: It would be considerably
20 less.

21 COMMISSIONER McCUTCHEON: You are
22 thinking of a list which would include the more
23 expensive drugs needed for long periods, using your own
24 words. You would contemplate not included in this,
25 let's say, an expensive drug needed for a short period;
you are thinking of epilepsy, mental illness?

26 DR. FERGUSON: Yes. I would say that
27 it might take two to four months whether a patient was
28 to be kept on, say, steroids, and the immediate arrange-
29 ments for expensive drugs would have to be met by other
30 channels, and certainly that is going to absorb most of



Ferguson

9837

1
2
3 the cases.

4 COMMISSIONER BALTZAN: Dr. Ferguson,
5 would you help me understand this one sentence, please?
6 It is on page 5:

7 "When the evidence is uncertain or
8 "advantages questionable the dubious
9 "items will be left in the sector of
10 "private enterprise."

11 I can take two meanings. For instance, private
12 enterprise, producers to establish their value. Do
13 you apply that?

14 DR. FERGUSON: Yes.

15 COMMISSIONER BALTZAN: Or experimenta-
16 tion by trial and error through doctors' prescriptions.
17 In other words, put them on the market?

18 THE CHAIRMAN: And see who lives.

19 DR. FERGUSON: Well, we are doing that
20 on quite a large scale, aren't we?

21 COMMISSIONER BALTZAN: That is what
22 I want to know. It could be that. It is being done.

23 DR. FERGUSON: Yes, it is being done;
24 and it is a very good safety valve, too, because there
25 are very good drugs used in good faith by many people
26 which medical science has not been able to validate.
27 But I think it is a safety valve and a great personal
28 freedom which needs to be preserved.

29 COMMISSIONER BALTZAN: And there
30 are safeguards in your present practice?

DR. FERGUSON: The safeguards are
good, in spite of the tragic occurrences of recent weeks.



Ferguson

9838

I would say that the work of the Food and Drug Directorate has been extraordinary in the protection of the heedless public, much more than they deserve.

COMMISSIONER BALTZAN: Thank you very much.

THE CHAIRMAN: Thank you very much, Dr. Ferguson. We have kept you to the end of a long day and we appreciate your patience and goodwill.

DR. FERGUSON: It is a pleasure, sir.

THE CHAIRMAN: We will adjourn now until 9:30 on Monday morning.

---ADJOURNMENT.

ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

TORONTO

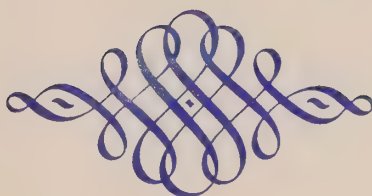
ONT.

VOLUME NUMBER:

52

DATE:

MAY 14 1962



OFFICIAL REPORTERS

ANGUS, STONEHOUSE & CO. LTD.
BOARD OF TRADE BLDG.
11 ADELAIDE ST. W.
TORONTO

364-5865

364-7383

VOLUME
INDEX

THE FACULTY OF MEDICINE, UNIVERSITY
OF TORONTO

9873

OF TORONTO UNIVERSITY

9889

THE FACULTY OF PHARMACY, UNIVERSITY
OF TORONTO

9893

THE SCHOOL OF HYGIENE, UNIVERSITY OF
TORONTO

9899

THE SCHOOL OF PHYSICAL AND HEALTH

9901

BALTIMORE & BEST DEPARTMENT OF MEDICAL
RESEARCH, UNIVERSITY OF TORONTO



VOLUME 52

INDEX

Page No.

STATEMENT BY DR. CLAUDE BISSELL,
PRESIDENT, UNIVERSITY OF TORONTO

9839

THE FACULTY OF MEDICINE, UNIVERSITY
OF TORONTO

9847

TEACHING HOSPITALS, UNIVERSITY OF
TORONTO

9872

THE FACULTY OF DENTISTRY, UNIVERSITY
OF TORONTO

9896

THE FACULTY OF PHARMACY, UNIVERSITY
OF TORONTO

9929

THE SCHOOL OF HYGIENE, UNIVERSITY OF
TORONTO

9957

THE SCHOOL OF PHYSICAL AND HEALTH
EDUCATION, UNIVERSITY OF TORONTO

10006

THE SCHOOL OF NURSING, UNIVERSITY
OF TORONTO

10015

BANTING & BEST DEPARTMENT OF MEDICAL
RESEARCH, UNIVERSITY OF TORONTO

10048



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

1
2
3 ROYAL COMMISSION ON HEALTH SERVICES

4 Proceedings of the hearings
5 held in Toronto, Ontario,
6 on the 14th day of May, 1962.

7 COMMISSION MEMBERS:

8 Chief Justice EMMETT M. HALL -- Chairman

9 MISS ALICE GIRARD, R. N.

10 DR. C. L. STRACHAN

11 DR. ARTHUR F. VAN WART

12 MR. M. WALLACE McCUTCHEON, Q.C.

13 PROF. O.J. FIRESTONE

14 DR. DAVID M. BALTZAN

15 COMMISSION COUNSEL:

16 MR. R. N. HALL, Q.C.

17
18 MEDICAL CONSULTANT:

19 DR. PIERRE JOBIN

20
21 DIRECTOR OF RESEARCH:

22 PROF. BERNARD BLISHEN

23
24 COMMISSION SECRETARY:

25 MR. N. LAFRANCE
26
27
28
29
30



Proceedings of the hearings
held in Toronto, Ontario,
on the 14th day of May, 1962.

COMMISSION MEMBERS

Chief Justice BARTY M. HALL - Chairman

DR. C. J. SPAGHAN

MR. A. J. F. VAN WAT

MR. M. WATSON ROBERTSON

PROF. W. L. KIRKSTONE

DR. DAVID M. DALRYMP

COMMISSION SECRETARY

DR. J. H. F. LEE

DIRECTOR OF INVESTIGATION

MR. J. H. F. LEE

COMMISSION SECRETARY

DR. J. H. F. LEE



---On resuming at 9:30 a.m.

THE SECRETARY: Mr. Chairman, I would like to call on Dr. Bissell to make a short statement before we begin with the University Faculties. This statement will be known as exhibit 269.

---EXHIBIT NO. 269

Statement of Dr. Bissell.

STATEMENT BY DR. CLAUDE BISSELL

APPEARANCE:

Dr. Claude Bissell.

DR. BISSELL: May I remain seated?

THE CHAIRMAN: If you would.

DR. BISSELL: Chief Justice and members, first of all, sir, may I express my satisfaction that you are meeting here at this university and in a residence over which at one stage of my career I had the happiness to preside. My submission will be very brief indeed and will be in the best presidential tradition rather general, but I hope not platitudinous. You will hear from my colleagues, a good number of them, in subsequent submissions which will deal with some of the specific areas. My statement deals with the general picture of this university and to a few general points which are relevant to the work of your Commission, and also to the study of medicine and the various allied health services. I am not going to read the submission, sir, line by line. I would like to make a few general



Bissell

9840

editorial comments upon it, just to bring out the major points which are presented.

The first paragraph is a straight historical paragraph which points out the long historical creation of the study of medicine and the allied disciplines in this university. In the second paragraph a statement, I hope, a clear and categorical statement that a university, and I think this view is shared by my colleagues here and elsewhere, that the best administration, the best facilities and the best teaching for these professional faculties occur in a university. I have just returned from a trip to China and Thailand, and in these countries there is a tendency to separate the faculties from the university with results, it seems to me, that are not entirely satisfactory. We are still clinging to the more typical western and democratic approach, that these faculties of medicine and allied professions are liberal professions which can best be taught in the atmosphere of the university.

In the second paragraph I point out the increasing national character of these problems and the essential nature, the necessity for looking at them in a national context. May I draw your attention, sir, to the sentence at the end of the paragraph, the major paragraph on page 2:

"We also note with satisfaction and
"interest the increasing part which our
"university medical centres are prepared
"to play in the education and training



1
2
3 "of workers from many other parts of
4 "the world, particularly those areas
5 "which are making such heroic efforts
6 "to raise the social and medical standards
7 "of their people in Africa, Asia, and
8 "the Far East."

9 I know, sir, this Commission is concerned
10 with the problem of a national nature and that you are
11 not inclined to embrace this great complex and
12 international problem, but I think inevitably this
13 country, and this university is going to be deeply
14 involved. If I may refer to my recent experience, again,
15 in Thailand which is a country of 28 million peoples,
16 there are at the present time two medical faculties.
17 They are trying to establish an additional medical
18 faculty, they are looking towards this university for
19 help, that is help of a general nature, advice, and
20 also I would think for some direct assistance in the
21 actual professional work of the faculty. It seems
22 these are obligations, sir, that a university like the
23 University of Toronto cannot very well avoid, indeed
24 an obligation that given the necessary resources we
25 would welcome. I know that Dean Hamilton and my
26 colleagues would share this view.

27 I refer on page 3 to attempts having
28 being made here, already proved successful attempts,
29 to bring together somewhat informally, but nevertheless
30 within the administrative structure, eight divisions in
this campus which are concerned with various aspects
of the health sciences, the medical science advisory



1
2
3
4 council. Now, the Medical Science Advisory Council is
5 under the chairmanship of Dr. MacFarlane who was for
6 15 years the distinguished Dean of the Faculty of
7 Medicine. We are trying to emphasize, gentlemen, the
8 importance of these various divisions of the University,
9 and also the necessity of achieving a degree of coherence
10 and co-ordination which would be lacking unless there
11 was this constant liaison. The Medical Science Advisory
12 Council has already done helpful work in the preparation
13 and presentation of this brief, and also in the area
14 of the preparation for overseas students to which I
15 have just referred.

16 The last part of the brief, simply
17 refers in very general terms to the specific contributions
18 made by the various divisions, the major divisions as
19 far as your interests are concerned. The Faculty of
20 Medicine refers to the elaborate and increasing
21 work of that faculty, and then goes on to talk about
22 pharmacy, nursing, dentistry and the other related
23 activities.

24 Just to conclude, sir, you will
25 shortly hear from the representatives of the different
26 divisions. You will learn from them something of their
27 contributions to the complex problem of providing
28 personnel and research and investigation and of the
29 necessity of building of modern health services for
30 Canadians. Of course, in several instance they will
have recommendations for your consideration. I might,
sir, conclude by saying I look upon the development of
these areas as being of primary importance. A university



1
2
3
4 president of such a complex university such as the
5 University of Toronto is faced with increasingly
6 bewildering problems in that the medical services, as
7 you are acutely aware, are terribly expensive. There
8 are many demands upon time, many demands upon organiza-
9 tion that are not common to the other divisions. There
10 is always a tendency when you have such a complexity,
11 such a concentration for a split to develop between
12 the more orthodox sections of the university, the
13 sections devoted to the less complex, the less elaborately
14 professionalized areas, and the areas devoted to
15 medicine. I look upon any such split, sir, as a major
16 disaster in the university, and I am acutely aware of
17 the fact that this division will occur unless there
18 is directed into medicine and the allied health services
19 a kind of support which is greater than that now
20 available to the other divisions of the university.
21 Thank you sir.

22 THE CHAIRMAN: Thank you very much,
23 Dr. Bissell. It is very good of you to come here this
24 morning and to give us the encouragement of your
25 presence, and the fact that you are displaying this interest
26 in the Commission and in the work of the faculties of
27 your university in relation to the Commission. We
28 are grateful also to you for the accommodation which
29 we have here. We are finding it very pleasant.
30 Tomorrow I think we move to the Senate Chamber because
this place is occupied. We will have the pleasure of
sitting in the Senate for one day a short term, perhaps,
but even that I suppose is more than most people achieve.



1
2
3
4 We are grateful to you. We are looking forward to
5 the submissions from the various faculties today. This
6 day is allocated as University of Toronto Health Faculties
7 Day, as far as the Commission is concerned. Thank you
8 very much.

9 COMMISSIONER FIRESTONE: Mr. Chairman,
10 I wonder if I might ask Dr. Bissell a general question.
11 We will have a number of specific questions as we go
12 along to the various submissions that are before us.
13 In reading over these various submissions one becomes
14 impressed with the complexity of the task facing the
15 University, the question of training of medical
16 personnel and other health personnel in numbers that
17 you have never attempted before, more research, the
18 creation of new facilities, the obtaining of adequate
19 staff to deal with this. It strikes me you are facing
20 a major financial problem in achieving this very large
21 program. My question to you, sir, do you feel the
22 existing methods of financing this expansion that is
23 ahead are adequate in overall terms.

24 DR. BISSELL: No, sir, I don't think
25 they are adequate. In the medical and allied services.
26 I hinted in my concluding remarks that I didn't think
27 they are adequate. Unless there are more adequate
28 resources available to these allied divisions there
29 may occur a split within the university. The very
30 nature of them makes it impossible, it seems to me,
to continue in the conventional channels of the
university financing. University financing is conceived
primarily in promotion of, shall we say, students and



1
2
3
4 faculties of arts and sciences, which is after all the
5 basic faculty of the university. I know you would all
6 agree with this. This concept of financing, of course,
7 is not adequate to the more elaborate and more extensive
8 professional faculties, and if the medical faculties
9 and the dental faculties and the other faculties are to
10 be placed in, as I hope they will be, on a full time
11 basis, then, of course, the financial problem is that
12 much greater. In brief, I don't think the present
13 methods of financing universities in terms of this
14 particular application are adequate.

15 COMMISSIONER FIRESTONE: What do you see
16 as the role of the Federal Government in this field,
17 in this changing field?

18 DR. BISSELL: Well, sir, I would hope
19 there would be a substantial role played by the Federal
20 Government in this field. This, of course, is a
21 hazardous subject, as you know, but I think there should
22 be more definite principles of action where by the
23 responsibilities in certain specific areas are accepted
24 by the Federal Government. The Federal Government, as
25 you know, makes very substantial contributions, direct
26 and indirect to the faculties of medicine and their
27 allied faculties. I don't think the Federal Government
28 has worked out any philosophy of financing as far as
29 the universities are concerned. The universities on
30 their side, sir, are content with a very simple process
of saying we want more, which is a fundamental approach
to financing, but we haven't yet reduced our requests
to what you might call a philosophical basis.

...of the ... which is ... all the ...
... I know ...
... of ...
... elaborate and ...
... the ...
... the ...
... I hope ...
... the ...
... I don't think the ...
... of ...

... When do you ...

... the ... in this field,
...
... I would hope
... the Federal
... of course, is a
... but I think there should
... by the
... as
...
... and their
... the Federal ...
... as the
... the ...
... process
... approach
...
...



1
2
3
4 COMMISSIONER FIRESTONE: Just one
5 last question, Dr. Bissell, we have had a number of
6 suggestions that a national health planning body be
7 established to deal with principles, philosophy,
8 programming et cetera. Now, I gather from this submission
9 you have a considerable amount of university planning
10 in mind in the field of health. I take it you would
11 be in favour, perhaps, of university planning in the
12 health field and national health planning being
13 co-ordinated and worked together towards the objectives
14 that are set out, being set out as being desirable
15 in this field?

16 DR. BISSELL: In general, yes, sir,
17 I think so although I am not acquainted with the
18 specific nature of the proposal about the national
19 planning that you refer to, but we are, in our own
20 area, as you say, trying to work out a long range plan,
21 and I should think with the elementary precaution of
22 co-operation on a national basis.

23 THE CHAIRMAN: Thank you very much.
24
25
26
27
28
29
30



1

/ss 2

9847

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

THE SECRETARY: The next brief to be submitted is that of the Faculty of Medicine, University of Toronto and it will be known as Exhibit 270.

---EXHIBIT 270: Submission of Faculty of Medicine, University of Toronto.

THE SECRETARY: The Dean has also filed with me a report of the General Faculty of Medicine for the year 1960-61, which will be Exhibit 270A.

---EXHIBIT NO. 270A: Report of General Faculty of Medicine, 1960-61.

S U B M I S S I O N O F
THE FACULTY OF MEDICINE, UNIVERSITY OF TORONTO

APPEARANCES:

DR. JOHN HAMILTON, Dean
DR. W.A. OILLE, Director Curriculum Study Committee

DEAN HAMILTON: Mr. Chairman, with your permission I will read the conclusions and recommendations of the brief with some comments to elucidate statements included.

The Faculty of Medicine of the University of Toronto is submitting this Brief for the purpose of presenting to the Commission problems of medical education and some aspects of this medical centre that are unique, and therefore have not been included in other presentations such as that of the Association of Canadian Medical Colleges.



is that of the Faculty of Medicine, University of Toronto
and it will be known as Exhibit 27C.

--- Exhibit 27C: Submission of Faculty of
Medicine, University of

the report of the Faculty of Medicine for the
year 1960-61, which will be Exhibit 27D.

--- Exhibit 27D: Report of General Faculty
of Medicine, 1960-61.

THE FACULTY OF MEDICINE, UNIVERSITY OF TORONTO

Dr. A. A. ...

... Mr. Chairman, with

your recommendation I will read the conclusions and recommendations
of the report with some comments to elucidate some
points.

is the Faculty of Medicine of the University
of Toronto is submitting this report for the purpose
of presenting to the Council some problems of medical education
and some aspects of this medical centre that are
... have not been included in other
... of the Association of Canadian



Hamilton 9848

Because of the size of the city and the University, the clinical and basic science facilities are extensive so that in the four areas in which a medical school functions, that is: undergraduate and graduate teaching, research, and the continuing education of the physician, the University of Toronto is the largest in Canada. The number of physicians receiving graduate education and continuing medical education in this centre is very large and is increasing annually, having already reached the point where they greatly exceed the number of undergraduate medical students.

CONCLUSIONS AND RECOMMENDATIONS

1. The Faculty of Medicine of the University of Toronto agrees with and endorses the recommendations in the Briefs presented to the Commission by both the Royal College of Physicians and Surgeons of Canada and the Association of Canadian Medical Colleges.

2. The Faculty of Medicine of the University of Toronto agrees with and would like to see implemented the recommendations contained in the Report of Dr. R.F. Farquharson: "Medical Education in Canadian Universities".

MEDICAL MANPOWER

3. We agree with the conclusions drawn from the study carried out by the Canadian Medical Association and the Association of Canadian Medical Colleges that Medical Faculties in Canada must by 1970 graduate 20 per cent more doctors than in 1961 and that, by 1980, about 50 per cent more must be graduated than in 1961.

If I may point out in relationship to



...of the size of the ...

...the University, the ... and basic science ...
...and ... in the ... in which a ...
...that is: ... and graduate ...
...and the ... of the ...
...the University of Toronto is the largest in ...
...the number of physicians receiving graduate edu- ...
...and continuing ... in the centre ...
...is very large and is ... having already ...
...the point where they greatly exceed the number of ...
...into ...

... ..

1. The Faculty of Medicine of the University of Toronto ... and endorses the recommendations in the ... to the Commission by both the ... of the ... and ... and the ... of the ...

The Faculty of Medicine of the University of Toronto agrees with and would like to see implemented the recommendations contained in the Report of Dr. ... Medical Education in Canada ...

... ..

... we agree with the ...
...by the Canadian Medical Association ...
...of the Canadian Medical Association ...
...in the ...
...that is ... and ...
...in ...



Hamilton 9849

this paragraph, the estimates of the number of medical manpower of the Canadian Medical Association had not taken into consideration recent statistical studies in Great Britain regarding the increase in population relative to the number of medical students currently enrolled and being graduated from British medical universities. I have been informed by the authorities at the Middlesex Hospital of the University of London that all the medical schools of the University of London are trying to increase enrolment by 5% in the coming year because they are not graduating enough doctors to fulfill their own need. This has a direct bearing on our problem, because we have been receiving so many immigrants from Great Britain in the past few years, the implication is the number of immigrants will fall off.

4. The Faculty of Medicine of the University of Toronto graduated some 150 doctors in 1961 and will do so in 1962. This number could and will be increased to 175 by 1967. This expansion should only be a temporary expedient because a school graduating more than 150 medical students per year becomes inefficient in teaching, research and administration. Moreover this relatively small increase in graduates will not materially effect the overall requirement for physicians in the country as a whole.

5. It is our opinion that the only solution to the problem of sufficient medical graduates in Ontario during the next fifteen years lies in the development as soon as possible of one new Medical School in Ontario to graduate 90 doctors per year by 1972. A second new Medical School of equal size should begin to enrol students by 1970, which means the first class would

the Registrar, the Registrar of the number of medical
graduates of the University of London has not

been able to correlate the recent statistical studies in
Great Britain regarding the increase in population

relative to the number of medical students currently
enrolled and being graduated from British medical univer-

sities. I have been informed by the authorities at the
St. Andrew's Hospital of the University of London that all

the medical schools of the University of London are trying
to increase enrollment by 15% in the coming year because

they are not graduating enough doctors to fulfill their
own need. This has a direct bearing on our problem.

Because we have been receiving so many immigrants from
Great Britain in the past few years, the implication is

the number of immigrants will fall off.
The Faculty of Medicine of the Uni-

versity of London, graduated some 150 doctors in 1961 and
will do so in 1962. This number could and will be

increased to 200 by 1965. This expansion should only be
a temporary expedient because a school graduating more

than 100 medical students per year becomes inefficient in
teaching, research, and administration. Moreover this

relatively small increase in graduates will not materially
alter the overall recruitment for physicians in the

country as a whole.
It is my opinion that the only solu-

tion to the problem of sufficient medical graduates in
order to carry the next fifteen years in the develop-

ment of our country is the establishment of a medical school in
the United States of America. The first step in this
direction is the establishment of a medical school in the



Hamilton 9850

graduate in 1974-75.

6. In our opinion lack of financial support is not a major cause of lack of applicants for Medicine in this area. It is probable that in other sections of Canada this may be a very important factor. If we are to progressively increase enrolment of medical students in Ontario, more student financial assistance will be mandatory. Today we require about \$100,000 per annum more student assistance than we have available; this should be half loan and half bursary. If any broad scheme of student financial assistance is contemplated in the future it should be based on academic standing.

7. The ultimate objective of producing good doctors would be greatly enhanced by increasing summer work opportunities in research, basic science and clinical areas. This would maintain and advance the student's medical motivation. Summer work in medical fields should pay the student about \$300 per month.

FACULTY FINANCIAL SUPPORT

8. There should be an increase in remuneration of academic full-time personnel in Basic Sciences, Clinical Sciences and Administration sufficient to retain them in this School.

The point here is that the higher salaries obtaining in the American universities is a fact that draws people and they are continually being solicited from the United States to emigrate as there is a great shortage of trained medical personnel in that country as well.

9. Part-time clinical teachers in all



...in the ...

In our opinion lack of financial

support is not a major cause of lack of applicants for

positions in this area. It is probable that in other

sectors of service this may be a very important factor.

If we are to progressively increase enrollment of medical

students in Ontario, more student financial assistance

will be mandatory. Today we require about \$100,000 per

annum more student assistance than we have available.

This amount is half loan and half bursary. If any form

scheme of student financial assistance is contemplated in

the future it should be based on academic standing.

The ultimate objective of providing

good doctors would be greatly enhanced by increasing

summer work opportunities in research, basic science and

clinical areas. This would maintain and advance the

student's medical motivation. Summer work in medical

fields should pay the student about \$500 per month.

There should be an increase in remuneration

of academic full-time personnel in basic sciences,

clinical sciences and administration sufficient to retain

them in the service.

The point here is that the higher

salaries only in the medical universities is a factor

in the recruitment of people and they are continuing to be

drawn into the service. There is a point

where the medical personnel in this country

...the ...



Hamilton 9851

departments must receive remuneration in proportion to the amount of work and time they expend in both undergraduate and postgraduate teaching, in continuing education with a physician on patient care and in research.

CLINICAL TEACHING

10. We wish to strongly support the recommendation from the Teaching Hospitals for capital grants to establish and maintain teaching and research areas.

11. Closed teaching units, as defined by the Association of Canadian Medical Colleges, must be preserved to maintain efficient undergraduate and postgraduate training.

12. Outpatient Departments are an integral part of medical education and urgently require financial assistance to maintain and expand their role in student training.

THE CHAIRMAN: Thank you very much, Dean Hamilton. Just on that last statement about the out-patient departments, in what way could there be further expansion of assistance to the medical college in out-patient services in a city like Toronto or any one of the places where you have a teaching college?

DEAN HAMILTON: Assistance through the university, Mr. Chairman, you mean to the out-patient service?

THE CHAIRMAN: No, to the university from the further development of out-patient services. You see, we are hearing representations that out-patient services ought to be expanded not only in the teaching



Department must receive remuneration in proportion to the amount of work and time they expend in both undergraduate and postgraduate teaching, in continuing education with a physician on patient care and in research.

10. We wish to strongly support the recommendation from the Faculty Institute for capital grants to subsidize and maintain teaching and research

11. Closed teaching units, as defined by the Association of Canadian Medical Colleges, must be provided to maintain efficient undergraduate and postgraduate training.

12. Closed teaching departments are an integral part of medical education and should receive financial assistance to maintain and expand their role in student

education. Just as that statement about the out-patient department, in what way could there be a transfer of funds or resources to the health colleges in out-patient departments as a duty like reports of any one of the other departments have a teaching college?

13. We wish to see assistance through the University, the Government, and the out-patient

and the further development of out-patient services. We are pleased in cooperation with out-patient services to be expanded not only in the teaching



Hamilton 9852

areas, but in all hospitals, and for various reasons.

I was wondering if you saw any value in this idea of the general expansion to a teaching unit, to the college?

DEAN HAMILTON: The out-patient department is an integral part of our teaching unit. We require the out-patient services and patients in the out-patients to enable us to follow patients from the outset of their ailment when they first come to the out-patients through their active treatment which may be in hospital. We wish to follow them from their convalescent and chronic care if that is the course of their illness, we wish to follow them following their discharge from active treatment beds, chronic beds through our out-patient department. In other words, it is part of our observation of disease throughout the whole of its course to either its culmination or its resolution.

THE CHAIRMAN: Well, at present you have the out-patients in the teaching hospitals?

DEAN HAMILTON: Yes, sir.

THE CHAIRMAN: If we accept the proposition that there will be out-patient departments in all hospitals, is it going to cut down the availability of teaching material which is now being directed through the teaching hospitals?

DEAN HAMILTON: I cannot answer that, I do not know except to say that the numbers of patients coming to the out-patient department of our teaching hospitals has fallen off in sum in recent years, has shown a very slow increase in our principal teaching hospitals. There has not been, in other words, the pressure on the



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Hamilton 9853

out-patient service, to the best of my knowledge, to
expand the same way there is on the in-patient service,
the demand for active treatment beds. I do not know if
that answers your question?



Question 100

...-Patent and Copyright, is the date of the knowledge, is
essential, the same way there is on the in-patient service,
the demand for active treatment. I do not know if
that answers your question.



Hamilton

9854

THE CHAIRMAN: I follow you.

COMMISSIONER BALTZAN: Just in connection with that, is there not sort of a general economic trend of people who do not choose to go to the so-called old-fashioned, crowded out-patient department, and also, too, they have so many more closer attachments than ever before with their own attending physicians; this decline in attending out-patient departments.

DEAN HAMILTON: I think this decline, sir, is certainly related to the greater affluence of the population. The ability of people to pay for their own physician's services.

At the same time, I think that we still have people coming to the out-patient department in a great metropolitan area like this for the reason that, again, there are people who are, although not quite indigent but who have not, perhaps, sufficient money, and again for the reason that the standard of medical care available in the out-patient services of our teaching hospitals is of a very high calibre and is recognized as such by the people in this area.

COMMISSIONER BALTZAN: I don't deny that part of it. I am perfectly in sympathy with things as you see them, but I am thinking in terms of the probability of having to re-orient your teaching approach to make up for this gap that is developing, and the reduction in the attendance at out-patient departments as, for instance, by preceptorships, assistanceships; say, the old term of apprenticeships, in order to get experience which one gets in an out-patient department.



THE CHAIRMAN: I follow you.

THE CHAIRMAN: I follow you.

In the last, is there not a sort of a general economic trend of people who do not choose to go to the so-called out-patient department, crowded out-patient department, and also, too, they have so many more. I mean at least that over before with their own attending physicians; this decline in attending out-patient department.

THE CHAIRMAN: I think this decline, sir,

is certainly related to the greater affluence of the population. The ability of people to pay for their own physician's services.

At the same time, I think that we still

have people coming to the out-patient department in a great metropolitan area like this for the reason that,

again, there are people who are, although not quite

indigent but who have not, perhaps, all latest money,

and again for the reason that the standard of medical

care available in the out-patient services of our teaching

hospital is of a very high caliber and is recognized as

such by the people in this area.

THE CHAIRMAN: I don't deny that

part of it. I am perfectly in sympathy with things as

you see them, but I am thinking in terms of the probability

of having to re-evaluate your teaching approach to

make up for this gap that is developing, and the reduction

in the attendance at out-patient departments as, for

instance, by precept, perhaps, assistantship, say, the

all term of specialty training, in other words, in other

words, one goes in an out-patient department.



Hamilton

9855

DEAN HAMILTON: You mean in terms of teaching, sir?

COMMISSIONER BALTZAN: Yes. It is possible. One may have to think in terms rather than trying to re-herd or herd those people again towards out-patient departments in hospitals. I will just leave that thought with you. That was raised before a number of times. That has been a trend right along in that there is a gradual reduction in attendance upon out-patient departments of hospitals.

DEAN HAMILTON: Sir, we are acutely aware of this, that there has been a reduction. We still regard, however, the maintenance of those out-patient services as essential to our teaching units and our whole broad teaching program.

I do not feel that a preceptorship program would answer the same purpose. We hope that the re-organization of our out-patient services in terms of increasing the facilities or modernizing the facilities, making the surroundings more amenable and closer to what the out-patient might meet in a doctor's office; this kind of improvement will continue to attract patients to our out-patient department.

COMMISSIONER BALTZAN: That is exactly the sort of thinking that I wanted to ask you about. Only one other thing ---

COMMISSIONER McCUTCHEON: You would like to have the facilities of the Toronto General Hospital comparable to those of the Cornell Medical Centre?

DEAN HAMILTON: Yes.



Hamilton

9856

COMMISSIONER BALTZAN: Just one other comment. I thank you particularly, on page 9, the first paragraph; the first time that I see a breakdown of the time spent for part-time teachers. Of course, it varies, as you best know. You say that the part-time teachers at the University of Toronto actually undertake 6 to 10 hours of undergraduate teaching per week. And the last sentence: "A conservative estimate of time spent by part-time teachers in this medical faculty is 400 to 450 hours per year in the university and teaching hospital."

Some place I actually did a little bit of work. We haven't got it here; worked it out to something like one-quarter of 40-hour week, 12 months. In other words, a part-time teacher on this basis here spends about one-quarter of his time, roughly speaking, as a part-time teacher.

DEAN HAMILTON: Yes, sir.

COMMISSIONER BALTZAN: I think I saw elsewhere, not here, perhaps in some other brief, that the honorarium ranges around what?

DEAN HAMILTON: \$250 per annum.

COMMISSIONER BALTZAN: Is it worth more. Thank you.

COMMISSIONER FIRESTONE: Dean Hamilton, in paragraph 4 on page 2 you say that you consider a school graduating more than 150 medical students per year becomes inefficient in teaching, research and administration.

COMMISSIONER McCUTCHEON: Dean Hamilton



Hamilton

9857

corrected it and said it is in danger of becoming inefficient.

COMMISSIONER FIRESTONE: Dean Hamilton, would you care to elaborate as to the reasons why you put that 150 figure as the demarcation line?

DEAN HAMILTON: If I may go back some years ago, the Faculty of Medicine did increase its enrolment following the last World War, and I think the maximum number of students graduated in any one year was 178 because of the pressure of returning veterans.

At that time, after much discussion of the size of classes, the Faculty came to the conclusion that to achieve optimum teaching, which means teaching in small groups, that they could not handle, with their existing facilities, more than 150 students per year.

There has been, since 1951 when that class graduated, a steady increase in the number of teachers and a steady reduction in the ratio of students per teacher.

COMMISSIONER FIRESTONE: Did I understand you to say, sir, that with the existing facilities it was difficult to train more than 150 people?

DEAN HAMILTON: Yes.

COMMISSIONER FIRESTONE: As your facilities are expanded could you graduate a larger class? I accept your judgment or your concept of efficiency because you know so much more about the subject but we would like some guidance from you.

DEAN HAMILTON: Well, sir, we could increase our facilities. We have now 8 teaching hospitals



Hamilton

9858

and the addition of more teaching hospitals would, we feel, increase administrative difficulties.

It really comes down to the control of the teaching in so many different places by so many different people in such small groups. It becomes increasingly difficult.

It is quite true we could add more hospitals, we could add more facilities and we could graduate 250 students. We do not feel that we could maintain our same standards by doing so.

COMMISSIONER FIRESTONE: I take it that this is one of the reasons why you say that, in paragraph 5, the only solution to the problem of sufficient medical graduates in Ontario during the next 15 years lies in the development as soon as possible of one new medical school in Ontario to graduate 90 doctors per year. Is that one of the basic reasons why you have come to that conclusion?

DEAN HAMILTON: Yes, Dr. Firestone. While we feel more doctors are needed, we do not feel the existing medical schools can expand, or at least, this medical school cannot expand to that extent.

COMMISSIONER FIRESTONE: What kind of criteria should one bear in mind in trying to find a location for a new medical school? I am not suggesting you tell us what location it should be, but are there some criteria that one should bear in mind in selecting a location?

DEAN HAMILTON: It is in paragraph 15, sir. We feel, first of all, the availability of students, potential medical students in the area, is important.

and the ability of more teaching hospitals would,

and, increase administrative difficulties.

It really comes down to the control of

the teaching in so many different places by so many

different people in such small groups. It becomes

increasingly difficult.

It is quite true we could aid some

hospitals, we could aid more facilities and we could

graduate 500 students. We do not feel that we could

maintain our same standards by doing so.

COMMISSIONER HASTINGS: I take it that

this is one of the reasons why you say that, in paragraph

2, the only solution to the problem of sufficient medical

graduates in Ontario during the next 15 years lies in the

development as soon as possible of one new medical school

in Ontario to graduate 50 students per year. Is that one

of the basic reasons why you have come to that conclusion?

While we feel more doctors are needed, we do not feel

the existing medical schools can expand, or at least,

the medical school cannot expand to that extent

COMMISSIONER HASTINGS: What kind of

criteria would one bear in mind in trying to find a

location for a new medical school? I am not suggesting

you tell us what location it should be, but are there

any criteria that one should bear in mind in selecting

a location

DR. HASTINGS: It is in paragraph 10,

the availability of students, the availability of students,

the availability of students in the area, as important.



Hamilton

9859

Secondly, the availability of patients, which means a large population and most important, the presence of a university.

COMMISSIONER FIRESTONE: Thank you.

May I now turn to paragraph 6 in which you refer to the desirability for additional financial assistance, and you suggest that an additional \$100,000 per annum in terms of student assistance would be required.

You say in paragraph 16 that this year your university has given \$156,000 to 342 students and the money has come from the Federal Government, Provincial Government and from private sources.

What contribution have you received from the Federal Government?

DEAN HAMILTON: Dr. Firestone, if you do not mind I will direct this question to Dr. Oille who has been in charge of our students' financial aid.

DR. OILLE: The money for student aid in Dominion-Provincial loans and bursaries, we cannot tell you the proportion of that that comes from Federal Government and the proportion from the Provincial but this year we had in the neighbourhood of \$40,000 Dominion-Provincial student aid and the remainder of the money came from other sources.

COMMISSIONER FIRESTONE: Now, sir, this \$100,000 figure which you are talking about in paragraph 6, is that a request for funds to be made available from Federal-Provincial sources?

DR. OILLE: Yes, and the way we arrived at that figure: in the last few years we have evolved a

...the ... of ...
... the ... of ...
... the ... of ...

... the ... of ...

... the ... of ...
... the ... of ...
... the ... of ...

... the ... of ...
... the ... of ...
... the ... of ...

... the ... of ...

... the ... of ...
... the ... of ...
... the ... of ...

... the ... of ...
... the ... of ...
... the ... of ...

... the ... of ...
... the ... of ...
... the ... of ...

... the ... of ...
... the ... of ...
... the ... of ...



Oille

9860

system where each student is interviewed and we know how much debt he has, and how much money he will require and this year our assistance program falls short of student needs by just under \$100,000.

We feel that it is important that a student should not graduate with a large debt because he is going to have to spend another 2 to 5 years with that debt and it will increase during that period and we have rather arbitrarily arrived at a figure of \$1,200 as about the maximum debt a student should have when he gets his M.D.

In our Faculty, to achieve that figure of financial balance, we need to spend about \$100,000 more.

COMMISSIONER FIRESTONE: That is very helpful and explains it very clearly, sir. Thank you. Paragraph 7, Dean Hamilton, you speak of the ultimate objective in producing good doctors would be greatly enhanced by increasing summer work opportunities in research, basic science and clinical areas. What are the opportunities for medical students today to find summer jobs in the areas which you have outlined in paragraph 7?

DEAN HAMILTON: Dr. Firestone, at present the opportunities in research are provided by assistanceships under research grants of the various granting agencies, including the Medical Research Council, the National Cancer Institute, the Multiple Sclerosis Association. I can't remember them all. You doubtless would be aware of them.



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

system where each student is interviewed and we know
how much cost he has, and how much money he will require
and this year our financial program falls short of
student needs by just under \$100,000.
We feel that it is impossible that a
student should not graduate with a large debt because he
is going to have to spend another 2 to 3 years with that
debt and it will increase during that period and we have
rather arbitrarily arrived at a figure of \$1,500 as
about the maximum debt a student should have when he gets
his M.D.

In our faculty, to someone that figures
of financial balance, we need to spend about \$100,000
more.
CONSISTENTLY FIRST: That is very
logical and explains it very clearly, etc. Thank you.
In paragraph 7, Dean L. Miller, you speak of the ultimate
objective in producing good doctors would be greatly
enhanced by increasing summer work opportunities in
research, basic science and clinical areas. What are
the opportunities for medical students today to find
summer jobs in the areas which you have outlined in
paragraph 7?

DR. MILLER: Dr. Finestone, at
present the opportunities in research are provided by
assistantships and research grants of the various
the National Cancer Institute, the National Institutes
of Health. I can't remember them all. You don't have
would be aware of them.



Hamilton 9861

Secondly, the individual departments of the university do endeavour to retain some money for this purpose in their budget. It isn't, however, very great. There is a small amount of endowment money that is specifically labelled for research assistance.

I cannot give you an answer as to the total quantity but the total number of such students employed in research in the summer is not any more than 25 or 30 and this is coming from memory, that is research, and in basic sciences, the two together.

In the clinical areas, following the third year, and I believe some exceptions following the second year, there are summer internships available, many of them in the United States where our students go.

I cannot give you the answer as to the number. There are very few available in Canadian hospitals.



2nd
Hamilton

Secondly, the individual departments

of the university is endeavour to retain some money
for this purpose in their budget. It isn't, however,
very great. There is a small amount of endowment money
that is specifically labelled for research assistance.
I cannot give you an answer as to the

total quantity for the total number of such students
employed in research in the summer is not any more than
25 or 30 and this is coming from money, that is research
and in basic sciences, the two together.

In the clinical areas, following the
third year, and I believe some exceptions following the
second year, there are summer internships available,
many of them in the United States where our students go.
I cannot give you the answer as to the
number. There are very few available in Canadian

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30



/ss

Hamilton 9862

1
2
3
4 COMMISSIONER FIRESTONE: Well, you
5 are just leading exactly to the point I was hoping you
6 could advise us on. Do I understand from you, sir, that
7 these 25 or 30 opportunities that exist in the field of
8 finding summer jobs in the field of basic science and
9 research, are these opportunities adequate for the number
of students you have?

10 DEAN HAMILTON: No, they are not
11 adequate.

12 COMMISSIONER FIRESTONE: What can be
13 done to provide more adequate opportunities for your own
14 student body, since you emphasize how important it is that
15 this type of research and basic science work be done in
the Summer months?

16 DEAN HAMILTON: We need more money for
17 such students. At the present time we are getting all we
18 can from the various research agencies. The difficulty
19 with this money, which we greatly appreciate I must say,
20 is that it is tied to a specific purpose. We feel that
21 it would be much better, the student would benefit more,
22 if we had money that was not specifically tied to a
23 particular research project, but that could be used to
24 support a student who could be directed into one of a
25 variety of different fields of research and
26 training in basic science, and furthermore in clinical
areas as well.

27 COMMISSIONER FIRESTONE: In other
28 words, what you are recommending, if I understand you
29 correctly, is that you would like to see general research
30 grants, as well as specific research grants?



1951

are just saying exactly to the point I was hoping you
 could advise us on. We understand from you, that
 these 25 or 30 opportunities that exist in the field of
 finding summer jobs in the field of basic science and
 research, and these opportunities adequate for the number
 of students you have?

DEAN HAMILTON: No, they are not

adequate. What can be
 done to provide more adequate opportunities for you in
 student body, since you emphasize now important it is that
 this type of research and basic science work be done in
 the summer months?

DEAN HAMILTON: We need more money for
 such students. At the present time we are getting all we
 can from the various research agencies. The difficulty
 with this money, which we greatly appreciate I must say,
 is that it is tied to a specific purpose. We feel that
 it would be much better, the student would benefit more,
 if we had money that was not specifically tied to a
 particular research project, but that could be used to
 support a student who could be directed into one of a
 variety of different fields of research and
 training in basic sciences, and furthermore in clinical
 areas as well.

COMMISSIONER FLETCHER: In other

words, what you are recommending, if I understand you
 correctly, is that you would like to see general research
 grants, as well as specific research grants?



Hamilton 9863

DEAN HAMILTON: Specific research grants for student assistance.

COMMISSIONER FIRESTONE: Yes, but these specific research grants for student assistance would be general, in the field of medical research and clinical work, this would be the specification you would envisage, but not a particular project?

DEAN HAMILTON: Yes, and such money would be much better included in the budget of the Faculty of Medicine.

COMMISSIONER BALTZAN: May I at this point say that you find that you have many more places to put such students in for three months than you have money provided to pay for them during that time. You have the places?

DR. HAMILTON: Yes, Dr. Baltzan, we could employ more.

COMMISSIONER BALTZAN: If you had the means of financing it?

DEAN HAMILTON: Yes.

COMMISSIONER BALTZAN: This is part education, and part also student assistance, pay?

DEAN HAMILTON: Yes.

COMMISSIONER FIRESTONE: And a contribution to research, I presume?

DEAN HAMILTON: Right.

COMMISSIONER VAN WART: Dean Hamilton, speaking of the bursaries for research with a string attached to them, so to speak, have the undergraduate students' bursaries strings attached also?



1935

DR. HAMILTON: Specific research

grants for student assistance.

COMMISSIONER: Yes, but these

specific research grants for student assistance would be

generally in the field of medical research and clinical

work, this would be the specification you would envisage,

but not a particular project?

DR. HAMILTON: Yes, and such money

would be much better included in the budget of the

Faculty of Medicine.

COMMISSIONER: May I at this

point say that you find that you have many more places to

put such students in for three months than you have money

provided to pay for them during that time. You have the

places?

DR. HAMILTON: Yes, Dr. Hamilton, we

could employ more.

COMMISSIONER: If you had the

means of financing it?

DR. HAMILTON: Yes.

COMMISSIONER: This is part

of the grant, the part also student assistance, pay?

COMMISSIONER: And a contri-

bution to research, I presume?

DR. HAMILTON: Right.

COMMISSIONER: Now, Dr. Hamilton,

speaking of the pursuance for research with a string

attached to them, so to speak, have the undergraduate

students' purs also attached to it?



Hamilton 9864

DEAN HAMILTON: The Summer assistance-ships?

COMMISSIONER VAN WART: Yes, the bursaries that you speak of that you need here for undergraduate students, loans and bursaries? Well now, I assume that you have bursaries for the undergraduate students, have you?

DEAN HAMILTON: Yes.

COMMISSIONER VAN WART: Are there conditions attached to those bursaries, or are they free?

THE CHAIRMAN: You have now left the Summer area, and are talking in general?

COMMISSIONER VAN WART: Talking in general.

DEAN HAMILTON: Speaking generally, the condition is that the student must obtain a certain standard before he is eligible for a bursary.

COMMISSIONER VAN WART: But after he receives the bursary, there is no encumbrance on it at all?

DEAN HAMILTON: No.

COMMISSIONER FIRESTONE: In Paragraph 7, coming back to the Summer area, you also refer to clinical Summer work. Do I understand you correctly in saying that a number of students, since they cannot find opportunities in Canada, are going to the United States to do the clinical work?

DEAN HAMILTON: In the Summer, yes, Dr. Firestone.

COMMISSIONER FIRESTONE: What could be



London 1944

THE CHAIRMAN: The summer holidays

are

COMMISSIONER VAN WART: Yes, the

holidays that you speak of that you need here for your

academic students, for the summer holidays? Well, yes, I

assume that you have holidays for the undergraduate

students, have you?

COMMISSIONER VAN WART: Are there

conditions attached to these holidays, or are they free?

THE CHAIRMAN: You have now said the

summer area, are they talking in general?

COMMISSIONER VAN WART: Talking in

the condition is that the student must obtain a certain

standard before he is eligible for a holiday.

COMMISSIONER VAN WART: But all of us

received the holiday, there is no question of it.

THE CHAIRMAN: No.

COMMISSIONER VAN WART: In paragraph

, coming back to the summer area, you also refer to

the summer area. Do I understand you correctly in

saying that a number of students, since they cannot find

accommodation in the area, are going to the other cities

to do the official work?

THE CHAIRMAN: In the summer, yes.

COMMISSIONER VAN WART: What about the



Hamilton 9865

done to keep more of the students in Canada?

DEAN HAMILTON: To provide more similar opportunities in Canada, to be done in a variety of ways. In teaching hospitals, Summer internships, which I should imagine we would have much less difficulty in placing such students if we had bursaries within the University and could place our students in such institutions as we felt were qualified to train them during the Summer. Secondly, it would be possible too to have a preceptorship program, such as Dr. Baltzan mentioned earlier, that students could be attached to practitioners. If we had the money, however, and the control of where they were placed.

COMMISSIONER FIRESTONE: How many such bursaries, or financial assistanceships would you consider would be a reasonable number to be made available to the University of Toronto per year?

DR. OILLE: I think probably we have in the neighbourhood of 508 a year undertaking this type of Summer work. We would have no trouble at all in placing a hundred students, and I think this paying them \$300.00 a month, the student needs that to carry on his next year's work at school. We would rather see the students work in one of these areas than go out and drive a truck in the Summertime.

COMMISSIONER FIRESTONE: So that you are talking of how many of such bursaries as a desirable target?

DR. OILLE: I am quite sure we could readily use a hundred.



Hamilton

done to keep some of the students in Canada?

DEAN HAMILTON: To provide more similar

opportunities in Canada, to be done in a variety of ways. In teaching hospitals, summer internships, which I should imagine we would have much less difficulty in placing such students if we had bureaus within the University and could place our students in such institutions as we felt were qualified to train them during the summer. Secondly, it would be possible too to have a preceptorship program, such as Dr. Palmer mentioned earlier, that students could be attached to practitioners. If we had the money, however, and the control of where they were placed.

COMMISSIONER FLETCHER: How many such

bursaries, or financial assistantships would you consider would be a reasonable number to be made available to the University of Toronto per year?

Dr. GILLES: I think probably we have in

the neighborhood of 500 a year undertaking this type of summer work. We would have no trouble at all in placing a hundred students, and I think this paying them \$300.00 a month, the student needs that to carry on his next year's work at school. We would rather see the students work in one of these areas than go out and drive a truck in the

COMMISSIONER FLETCHER: So that you are

talking of how many of such bursaries as a desirable target?

Dr. GILLES: I am not sure we could

readily use a hundred.



Hamilton 9866

1
2
3
4 COMMISSIONER FIRESTONE: And it would
5 be \$300.00 a month for how many months?

6 DEAN HAMILTON: Four months.

7 COMMISSIONER FIRESTONE: So it is a
8 total sum of \$1,200.00 for the Summer per student?

9 DEAN HAMILTON: Yes.

10 COMMISSIONER FIRESTONE: Thank you
11 very much.

12 COMMISSIONER VAN WART: On Page 6 you
13 say that some 40 students from outside of Canada, and
14 they constitute an acute financial problem to the Univer-
15 sity. For information, have you any students under the
16 Colombo Plan at your university taking medicine?

17 DR. OILLE: I cannot tell you. We have
18 about 50 students in our enrolment from outside of Canada,
19 excluding the United States. We only have three or five
20 American students registered here, and the remainder of
21 this 50 comes from a great variety of areas in Asia and
22 the West Indies. I cannot tell you how many of them are
23 on the Colombo Plan.

24 COMMISSIONER VAN WART: But you have
25 some?

26 DEAN HAMILTON: I am not sure that we have
27 any at the moment, sir, from South-east Asia. We only
28 had one from Malaya, we had none from Ceylon. We have
29 one from Pakistan, who is not under the Colombo Plan.
30 The African students are not under the Colombo Plan.

COMMISSIONER VAN WART: Are any of the
foreign students financed by their governments?

DEAN HAMILTON: Yes, indeed they are.



CONFIDENTIAL - THIS IS A COPY

BY 100,000 A MONTH FROM THE MONTH OF

THE MONTH OF THE MONTH

CONFIDENTIAL - THIS IS A COPY

total of 10,000.00 for the summer months

CONFIDENTIAL - THIS IS A COPY

very much

CONFIDENTIAL - THIS IS A COPY

say that some 40 students from outside of Canada, and they constitute an acute financial problem to the university. For information, have you any students under the Colombo Plan at your university taking medicine?

OK, Mr. [Name]: I cannot tell you, as I have

about 50 students in our enrollment from outside of Canada, according to the United States. We only have three or four American students registered here, and the remainder of this 50 come from a great variety of areas in Asia and the West Indies. I cannot tell you how many of them are on the Colombo Plan.

CONFIDENTIAL - THIS IS A COPY

very

CONFIDENTIAL - THIS IS A COPY: I am not sure that we have any at the moment, but from South East Asia, we have had one from Malaya, we had none from Ceylon. We have one from Pakistan, who is not under the Colombo Plan. The African students are not under the Colombo Plan.

CONFIDENTIAL - THIS IS A COPY

to sign students: informed by the Government

CONFIDENTIAL - THIS IS A COPY



Hamilton 9867

COMMISSIONER VAN WART: The amount of financing to the university, is it adequate to support --

DEAN HAMILTON: To the best of my knowledge those that are supported by their governments are adequately supported. They have difficulty during the Summer in that sometimes they have not sufficient money to carry them over the Summer, and they search for Summer employment at one time or another.

COMMISSIONER STRACHAN: With respect to Summer work, are these students able to take this work after each year of the medical course, or are they confined to the latter years?

DEAN HAMILTON: Following their first year in medicine they are. They can really only be employed in basic science departments, in anatomy, and physiology and biochemistry. Following their second year their opportunities increase. They may then begin to work in hospitals and in research and in basic science, and following their third year, then the whole range, on the whole field of medicine is open to them for Summer employment in terms of further training.

COMMISSIONER STRACHAN: Would their remuneration be on a graduated scale then?

DEAN HAMILTON: The remuneration, sir, is related to their need to earn money to pay their fees for the next year. We have not felt that the remuneration was in proportion to, we were not paying them primarily for work done.

COMMISSIONER STRACHAN: Then this suggested \$300.00 per month is applicable to all years then?



Hamilton 334

OF MEDICAL AND NURSING: The amount of
 financing to the University, is it adequate to support --
 THE UNIVERSITY: In the past of my
 knowledge those that are supported by their Government are
 are adequately supported. They have difficulty during
 the summer in that sometimes they have not sufficient
 money to carry them over the summer, and they search for
 summer employment at one time or another.

to summer work, are these students able to take this work
 after each year or the medical course, or are they
 confined to the latter years?

DEAN HAMIL: Following their first
 year in medicine they are. They can really only be
 employed in basic and clinical problems, in anatomy, and
 physiology and histology. Following their second
 year their opportunities increase. They may then begin
 to work in hospitals and in research and in basic
 science, and following their third year, then the whole
 range, or the whole field of medicine is open to them for
 summer employment in terms of further training.

DEAN HAMIL: Would their
 remuneration be on a graduated scale?
 DEAN HAMIL: The remuneration, sir,
 is related to their need to earn money to pay their fees
 of the next year. We have not felt that the remuneration
 was in proportion to, we have not paying them primarily
 for work done.

DEAN HAMIL: 31/10/57: 11:45 AM

suggested \$50.00 per month in addition to all other things



Hamilton 9868

DEAN HAMILTON: It is applicable to all years. It is about the average we felt.

COMMISSIONER McCUTCHEON: Doctor Hamilton, you refer in your summary, in Paragraph 3, to the necessity of our graduating more doctors, and when you turn to Paragraph 13, on Page 4, you support that in part by a prediction that we will acquire fewer immigrant doctors from the United Kingdom. Can you tell me why you come to that conclusion?

DEAN HAMILTON: Yes, sir, and I regret --- I tried to find a reference to back this up, and was unable to. The information was obtained largely from Professor Kecknick, Professor of Medicine at the University of London, Middlesex School, who was here as a visiting professor during the month of April. He informed me that the medical schools of Great Britain had reduced their enrolment of medical students about five or six years ago, as it was considered that the number of graduates required for the expanding population wouldn't require as many as they were then taking in. They reduced their number. He informed me that the statistical predictions of population increase that were made some years ago, approximately ten years ago, have now been proven to be in error, that the population of some 52,000,000 which was predicted for some time after 1965, has already been reached. That the number of annual graduates from British medical schools is not adequate for a population of this size. That is at the present day, and therefore they are going to increase their enrolment of medical students, and he felt that



THAT WILL BE: It is applicable to

all cases. It is about the average of all.

...and then in your summary, in Paragraph 3, to
the necessity of the ... and when
you turn to Paragraph 13, on Page 4, you mention that
in part by a prediction that we will acquire fewer im-
grant doctors from the United Kingdom. Can you tell me
why you come to that conclusion?

DEAN HAMILTON: Yes, sir, and

regret --- I tried to find a reference to back this up,
and was unable to. The information was obtained largely
from Professor Kekelashvili, Professor of Medicine at the
University of London, Middlesex School, who was here as
a visiting professor during the month of April. He
informed me that the medical schools of Great Britain
had reduced their enrollment of medical students about
five or six years ago, as it was considered that the
number of graduates would be for the expansion of the population
wouldn't require as many as they were then taking in.
They reduced their numbers. He informed me that the
statistical predictions of population increase that were
made some years ago, approximately ten years ago, have
now been proven to be in error, that the population of
some 55,000,000 which was predicted for some time after
it has already been reached. That the number of
graduates from British medical schools is not
adequate for the population of this size. That is at the
present day, and therefore there are going to increase
their enrollment of medical students, and he felt that



Hamilton 9869

because of the increased opportunities for physicians in Great Britain there would be a reduced number seeking to emigrate to Canada. They have been losing, the exact number is not known, but a considerable proportion of the graduating class of physicians in Great Britain has emigrated to the Commonwealth, principally to Australia, New Zealand, and Canada. In the last ten years 1,621 physicians have come to Canada from Great Britain.

COMMISSIONER McCUTCHEON: Now, have they come to Canada because there was a surplus of medical manpower in the United Kingdom, or have they come to Canada because they felt that the opportunities and the conditions of practice were better here, just as during a situation which we certainly have not had a surplus of manpower, we have seen people, and you have referred to them, going to the States because they regarded the opportunities and conditions of practice to be possibly more satisfactory there. Why should this predicted shortage in the United Kingdom affect that type of consideration, or hasn't that been the consideration which brought these men out?

DEAN HAMILTON: I don't think I can answer this adequately. My impression is that a good part of the reason for the emigration to Canada has been the reduced opportunity in Great Britain. The number of places for physicians was not as great as it is here. My understanding was that it was not related entirely to the National Health Service. There are I know, physicians from Great Britain in this country who have told me that they have come because they were dissatisfied with the



1957

because of the increased opportunities for physicians in Great Britain, there would be a reduced number seeking to emigrate to Canada. They have been losing, the exact number is not known, but a considerable proportion of the practicing class of physicians in Great Britain has emigrated to the Commonwealth, principally to Australia, New Zealand, and Canada. In the last few years, 1,231 physicians have come to Canada from Great Britain.

COMMISSIONER McLEOD: Now, have

they come to Canada because there was a surplus of medical manpower in the United Kingdom, or have they come to Canada because they felt that the opportunities and the conditions of practice were better here, just as during a situation which we certainly have not had a surplus of manpower, we have seen people, and you have referred to them, going to the States because they regarded the and conditions of practice to be possibly

more satisfactory there. Why should this predicted shortage in the United Kingdom affect that type of consideration or hasn't that been the consideration which brought these men out?

DEAN HAMILTON: I don't think I can

answer this adequately. My impression is that a good part of the reason for the emigration to Canada has been the reduced opportunity in Great Britain. The number of places for physicians was not as great as it is here. I understand that it will not be related entirely to the National Health Service. There are 1,000, physicians from Great Britain in this country who have told me that they have come because they were dissatisfied with the



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Hamilton 9870

National Health Service. There are others, particularly in some of the specialties, but they come because there are no positions available for specialists.

I don't know whether Dr. Oille could answer that. He is more familiar with it.



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

Hamilton 9875

National Health Service. There are others, particularly
in some of the specialists, but they come because there
are no positions available for specialists.
I don't know whether Dr. Cille could
answer that. He is more familiar with it.



/hm

Oille

9871

1
2
3
4 DR. OILLE: I have heard a good many
5 answers to that question. I think they come for a
6 great variety of reasons and no one could be said to
7 predominate. I think the important fact is that in a
8 ten year period we get some 1,600 doctors educated
9 somewhere else, and we foresee in the next ten years
10 we are going to get a great many fewer than that, so
11 we will have to educate them ourselves at our own
12 schools.

13 COMMISSIONER McCUTCHEON: That
14 prediction is an educated guess?

15 DR. OILLE: It is.

16 COMMISSIONER McCUTCHEON: Thank you
17 very much.

18 THE CHAIRMAN: Thank you very much,
19 Dr. Oille, Dean Hamilton. What I say now may have
20 general application throughout the day. The nature
21 of the submissions from the faculties, the fact they
22 come from the faculties, makes it much less necessary
23 for members of the Commission to probe and question
24 than might otherwise be the case because the briefs
25 have been constructed, put forward so clearly and they
26 have been backed up with statistical information that
27 is available, so we have the briefs for study, and
28 beside that and perhaps equally, if not more important
29 we have the special study going on of medical education
30 and we are relying very heavily on Dr. MacFarland
and his group to amplify and to clarify many of the
things that might otherwise not be clear to us. Thank
you very much.



Oille

9872

DEAN HAMILTON: Thank you.

THE SECRETARY: We will now hear the submission of the Teaching Hospitals of the University of Toronto which will be known as exhibit 271. I understand Dean Hamilton will remain to present the brief with Dr. Janes.

---EXHIBIT NO. 271

Submission of Teaching
Hospitals of the University
of Toronto.

SUBMISSION OF

TEACHING HOSPITALS OF THE UNIVERSITY OF TORONTO

APPEARANCES:

Dr. John Hamilton
Dr. R. M. Janes
Dr. J. E. Sharpe
Mr. M.B. Wallace

DEAN HAMILTON: Mr. Chairman, members of the Royal Commission on Health Services may I present Dr. Janes, Professor of Emeritus of Surgery at the University of Toronto who is largely responsible for the preparation of this brief; Dean J.E. Sharpe, Superintendent of the General Hospital and Mr. M. Wallace, Superintendent of the Toronto Western Hospital.

May I apologize, sir, for the fact that this brief is not correctly bound. I will read the introduction and summaries with some minor modifications.

This brief has been prepared on behalf of the teaching hospitals affiliated with the University



1871

1871

112 55 572447; he will now have the
 permission of the Toronto Hospitals of the University
 of Toronto which will be shown as exhibit 271. I
 understand that Hamilton will remain to present the

Submission of Toronto
 Hospitals of the University
 of Toronto.

---I shall now say

Submission of

TRAINING IN NURSING OF THE UNIVERSITY OF TORONTO

Mr. John Hamilton
 Mr. M. James

APPENDIX

LEAH HAMILTON; Mr. Chairman, members
 of the Royal Commission on Health Services may I
 present Mr. James, Professor of Nursing at University of
 the University of Toronto who is largely responsible
 for the preparation of this paper; Dean J.E. Savage,
 Superintendent of the General Hospital and Mr. H.
 Wallace, Superintendent of the Toronto Western Hospital.
 May I apologise, sir, for the fact
 that this list is not completely a unit. I will read
 the introduction and summaries with some minor modifica-

This paper has been prepared on behalf
 of the Toronto Hospitals of the University



Hamilton

9873

of Toronto, including:

Toronto General Hospital

St. Michael's Hospital

Toronto Western Hospital

The Wellesley Hospital

Princess Margaret Hospital

Toronto Psychiatric Hospital

Women's College Hospital

Hospital for Sick Children

Because these hospitals have the special services and staff that a teaching hospital must have, they serve as referral centres for problem cases and attract patients from a wide area. Generally from 1% up to 30% of the patients in these hospitals come from beyond Metropolitan Toronto. As the hospitals provide the facilities for teaching at all levels, and for research, they constitute a major part of the medical school and yet are not an integral part of the University. Their relationship is by affiliation only, with the exception of the Toronto General Hospital, where the relationship is defined by a statute of the Province of Ontario.

The argument and body of this brief, together with Appendix #1, were prepared by the Emeritus Professor of Surgery, Dr. R. M. Janes, following consultation with the individual hospitals.

Appendix #2 was prepared by the Dean of Dentistry, Dr. R. G. Ellis, with the assistance of Dr. J. A. Pedler.



RECOMMENDATIONS AND SUMMARY:

1. A teaching hospital is one that is affiliated with a University for the purpose of teaching undergraduate and graduate medical students. We feel a definition of the teaching hospital is necessary.
2. Not less than 40% of the beds in such a hospital should be incorporated into one or more closed teaching units as defined by the Association of Canadian Medical Colleges.
3. Comprehensive hospital care should be available in a teaching hospital, including accommodation for short and long term illness, and convalescent and chronic care. An out-patient service is essential to such a hospital, both for treatment services and teaching.
4. The teaching hospital must provide special facilities to fulfil those functions that are both directly and indirectly associated with teaching. These include:
 - (a) An auditorium.
 - (b) Lecture theatres
 - (c) Clin rooms in each teaching unit
 - (d) Student laboratories, locker rooms, common rooms.
 - (e) Living-in accommodation for up to 20% of the final year students.
 - (f) Medical Art and Photography
 - (g) Experimental and research laboratories
 - (h) Office accommodation for the full time medical staff and the associated fellows



1. A teaching hospital is one that is
of limited size and a limited number of teaching
instructors and no more than 100 students. It is
the function of the teaching hospital is necessary
of a teaching hospital is to provide in such
a hospital as to be incorporated into one or more classes
teaching units as follows in the Association of

2. A teaching hospital should be
available in a teaching hospital, including accommo-
dation for short and long term illness, and convalescent
patients. A teaching hospital is essential
to such a hospital, both for treatment services and

3. A teaching hospital must provide
medical facilities to fulfill those functions that are
not only and in some cases associated with teaching,

(a) The teaching hospital
teaching unit
This is a teaching unit
teaching laboratories, lecture rooms, common

(b) Teaching laboratories for up to 100 of the
teaching students.
(c) Medical Art and Photography
(d) Microscopic and research laboratories
The teaching hospital for the full time medical
teaching unit is associated follows



(i) Equipment for teaching and the above special units

(j) Library

5. Because it is also a referral centre the teaching hospital must provide special clinical services. These may include:

(a) Cardiovascular surgery

(b) Pulmonary failure unit

(c) Renal failure unit

(d) Rehabilitation service

(e) Dental service

(f) Intensive care units

(g) Emergency service

(h) Clinical investigation unit

(i) Special diagnostic laboratories

6. The establishment for interne and resident staff must be large enough to provide service and yet allow the individual time for study and training. The number of internes and residents per hospital should be decided by agreement between the hospital and the University.

7. Instruction and training of auxiliary medical personnel has to a large extent become centred in the teaching hospitals. This necessitates teachers, space, and sometimes equipment for the following categories:

(a) Nurses, undergraduate and postgraduate

(b) Nursing assistants

(c) Dietitians

(d) Medical records librarians



...for teaching and the above ...

is

Because it is also a referral centre

The teaching hospital must provide special clinical

services, these may include:

- (a) Laboratory and x-ray
- (b) Clinical pathology unit
- (c) Special clinical unit
- (d) Rehabilitation services
- (e) Dental services
- (f) Outpatient clinic units
- (g) Intensive services
- (h) Clinical investigation unit
- (i) Special diagnostic laboratories

The establishment for interns and

residents must be large enough to provide services

and yet allow the individual time for study and training.

The number of interns and residents per hospital should

be decided by agreement between the hospital and the

Instruction and training of auxiliary

medical personnel may to a large extent become centred

in the teaching hospitals. This necessitates teachers,

staff, and sometimes equipment for the following

- (a) Nurses, undergraduate and postgraduate
- (b) Medical assistants
- (c) Laboratory
- (d) Medical records librarians



- (e) Medical secretaries
- (f) Laboratory technicians
- (g) Radiographic technicians
- (h) Medical social workers
- (i) Occupational and physical therapists
- (j) Speech therapists
- (k) Hospital chaplains

8. It is therefore recommended:

- (a) that the Hospital Insurance Act be amended to recognize the teaching hospital. There is no definition of the teaching hospital now in the Hospital Insurance Act
- (b) that grants-in-aid for capital construction, over and above those now obtainable, be made available to the teaching hospital from Federal funds, as the special needs of such a hospital relate to its teaching and university function, and this serves the nation as a whole. Such grants can be estimated on the basis of the amount of space necessary to provide those facilities listed in paragraph 4. above, and this can in turn be related to the number of teaching beds. This might approximate 100 sq. ft. per bed in a hospital with 300 teaching beds.
- (c) that grants-in-aid be made available to cover teaching equipment. This, again, on application as was possible formerly.
- (d) that additional grants-in-aid of capital construction be made available when the teaching



- (a) Hospital secretaries
 - (b) Hospital technicians
 - (c) Hospital dietitians
 - (d) Hospital social workers
 - (e) Hospital and physical therapists
 - (f) Hospital librarians
 - (g) Hospital janitors
5. That the Hospital Inservice Act be amended to
- to include the teaching hospital. There is no
- definition of the teaching hospital now in
- the Hospital Inservice Act
- (f) That provision for capital construction,
- and above those new standards, be made
- available to the teaching hospital from
- general funds, as the special needs of such a
- hospital relate to its teaching and university
- mission, and also serves the nation as a
- whole. When plans can be estimated on the
- basis of the amount of space necessary to
- provide those facilities listed in paragraph
1. above, and this can in turn be related to
- the number of teaching beds. This might
- approximately 100 sq. ft. per bed in a hospital
- with 100 teaching beds.
- (g) That a study be made available to
- teaching equipment. This, again, on applica-
- tion for use teaching hospital.
- That a study be made available of capital
- construction be made available when the teach-



Hamilton

9877

1
2
3 hospital provides the training of auxiliary
4 medical personnel listed in paragraph 7.
5 Alternatively, a separate institution for
6 the training of such personnel could be
7 established and affiliated with one or more
8 teaching hospitals. Such a separate establish-
9 ment is an optimum arrangement in a large
10 metropolitan area where there are a number
11 of hospitals duplicating the training of
12 auxiliary personnel. The centralization of
13 classroom instruction for auxiliary personnel
14 might well be done in a separate institution.
15 This would centralize training and eliminate
16 the duplication of courses that now occurs in
17 large centres, where each teaching hospital
18 offers courses. Thank you very much.

19 THE CHAIRMAN: Thank you Dean Hamilton.
20 I may open the subject you referred to in recommendation
21 number two on page S2. You refer to not less than 40%
22 of the beds should be incorporated into one or more
23 closed teaching units. Have you been able to discern,
24 have the teaching universities or teaching hospitals
25 been able to discern any change in the volume of
26 clinical material available since the Hospitalization
27 Act came into force on the first of January, 1959?

28 DEAN HAMILTON: I would ask Dr. Sharpe
29 and Mr. Wallace to answer this as they would be familiar
30 with the numbers of patients admitted to the teaching
areas in their respective hospitals.

THE CHAIRMAN: The basis is that



Hamilton

8877

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

hospital provided the training of auxiliary
 medical personnel listed in paragraph 7.
 Alternatively, a separate institution for
 the training of such personnel could be
 as outlined and affiliated with one or more
 teaching hospitals. Such a separate establish-
 ment is an obvious arrangement in a large
 metropolitan area where there are a number
 of hospitals conducting the training of
 auxiliary personnel. The centralization of
 instruction for auxiliary personnel
 might well be done in a separate institution.
 This would centralize training and eliminate
 the duplication of courses that now occurs in
 these centers, where each teaching hospital
 offers courses. Thank you very much.

THE CHAIRMAN: Thank you, Mr. Hamilton.
 I have open the subject you referred to in recommendation
 number 2, on page 22. You refer to not less than 40%
 of the total should be incorporated into one or more
 closed teaching units. Have you been able to dissem-
 inate the teaching universities or teaching hospitals
 been able to discuss any change in the volume of
 clinical material available since the Hospitalization
 Act came into force on the first of January, 1959?

MR. HAMILTON: I would ask Dr. Sharpe
 and Mr. Wallace to answer this as they would be familiar
 with the numbers of patients admitted to the teaching
 areas in their respective hospitals.

THE CHAIRMAN: The basis is that



Hamilton

9878

everybody, virtually everybody is a paying patient in the hospitals today in Ontario?

DR. SHARPE: For hospitals, that is correct, sir.

THE CHAIRMAN: Is that situation affecting the availability of clinical material?

DR. SHARPE: There has been no reduction as far as we are concerned in the availability of clinical material among the public.

COMMISSIONER BALTZAN: I didn't get your answer.

DR. SHARPE: There has been no reduction, Dr. Baltzan, in the clinical material available to our public wards or standard wards.

COMMISSIONER BALTZAN: That includes access for teaching?

DR. SHARPE: That is correct, sir.

DEAN HAMILTON: Dr. Janes, I think has something to add.

DR. JANES: Mr. Chairman, I should point there has been a shortage of hospital beds in the area and a great many patients have had to go in a teaching area as standard ward patients who would by choice have gone to semi-private and private wards. Many of those patients wouldn't have gone there had private and semi-private accommodation been available.

THE CHAIRMAN: By that do you mean you have sensed an aversion to being used as clinical material which they haven't been able to avoid because they have had to had beds wherever they are available?



Janes

9879

1
2
3
4 DR. JANES: I suppose, sir, there
5 are two facts: The first is they preferred accommodation
6 in semi-private or private rooms, to being in the
7 general ward, perhaps, that influences their choice as
8 well the question of teaching. The accommodation is
9 more desirable, and they apply frequently to add to the
10 amount that is allowed for the standard ward care and
11 go to the other accommodation.

12 THE CHAIRMAN: What we are concerned
13 with, we move into another area, what we are talking
14 about at the moment, historically the clinical material
15 came from the non-paying hospital patients.

16 DR. SHARPE: That is right.

17 THE CHAIRMAN: All hospital patients
18 are paying patients?

19 DR. JANES: Yes.

20 THE CHAIRMAN: Is that going to affect
21 the development in the course of hospital teaching in
22 the future, if you people are able to give an opinion
23 on it? Your experience has been rather short, it is
24 only three years.

25 DR. SHARPE: Not if we are, Mr. Chairman,
26 if I might reply to this, offering the type of services
27 in the facilities that we know should be there. I
28 think we could attract them by the level of teaching
29 and service that is available.

30 THE CHAIRMAN: At the present time
do those patients pay for their medical attention and
surgical attention or is that free, free to them at
the moment?



Wallace

9880

1
2
3
4 MR. WALLACE: Sir, we have a screening
5 process where a person may come in and if they have
6 semi-private or private coverage we don't permit them
7 to have private or semi-private rooms and remain orphans
8 medically. If they have private or semi-private
9 accommodation and no doctor coverage or no ability to
10 pay the doctor then they come in the standard ward
11 and are taken care of by the staff. We will not allow
12 people to do that, and, shall we say, impose upon the
13 doctor.

14 THE CHAIRMAN: We are staying in the
15 closed wards for teaching purposes?

16 MR. WALLACE: Yes.

17 THE CHAIRMAN: The discussion is in
18 that area?

19 MR. WALLACE: We haven't experienced
20 difficulty nor have we experienced difficulty having
21 sufficient numbers. It may be, as Dean Janes says
22 because there is a scarcity of accommodation, because
23 of our large waiting list many people are quite pleased
24 to go on the standard ward to get their accommodation
25 promptly.

26 -

27 -

28 -

Dr. WATSON: Sir, we have a screening

process where a person may come in and if they have
semi-private or private quarters we don't permit them
to have private or semi-private rooms and remain in them
at night. They have private or semi-private
accommodation and no doctor oversees or is able to
pay the doctor that they come in the standard ward
and are taken care of by the staff. We will not allow
people to be that, and, as I say, people from the
doctor.

Dr. WATSON: We are staying in the

closed ward for teaching purposes?

Dr. CHAIRMAN: The discussion is in

Dr. WATSON: We haven't experienced

difficulties nor have we experienced difficulty having
sufficient nurses. It may be, as Dean James says
because there is a scarcity of accommodation, because
of our large waiting list many people are quite pleased
to be on the standard ward to get their accommodation

Dr. WATSON:



Hamilton

9881

THE CHAIRMAN: I follow that quite easily.

DEAN HAMILTON: We are greatly concerned, the Medical Faculty is concerned, about the future supply of patients should the number of beds in the metropolitan area ever reach the point where the patients had a choice of accommodation.

THE CHAIRMAN: So one way of getting teaching material is to keep accommodation short?

DEAN HAMILTON: We feel one way to keep teaching patients is the way Dr. Sharpe said, we hope by the superiority of our accommodation, our medical care in our closed teaching units that people will seek admission to them.

COMMISSIONER McCUTCHEON: There is another question that the Chairman asked that was not answered; is the person in the standard ward bed charged for medical or surgical services today?

DEAN HAMILTON: He is not charged unless he is insured; if he holds insurance then a fee may be collected.

THE CHAIRMAN: From the patient's standpoint one of the benefits of going into the closed teaching wards, apart from the excellent service he will get, is the fact he may not have to pay?

DEAN HAMILTON: That is true.

THE CHAIRMAN: If we move forward to what we might call a comprehensive health services program in which all would be insured under one form or another or through some program that medical expenses would be



Hamilton

9882

paid, that is the question I would like to put to you; we are only leading to the thing in relation to the subject under discussion and that is the prepaid medical services for everybody. If that should come about in one form or another, how will it affect, or will it affect, the availability of clinical material for teaching?

DR. JANES: I think it should be made clear that no patients in the standard teaching ward are charged by the individual doctor; no doctor is allowed to collect a fee from this patient as an individual. I think that is an essential part of the teaching unit and it does not matter whether there are semi-private patients in it or not. Under no circumstances should the teaching staff be allowed to collect fees from these patients individually.

THE CHAIRMAN: If, in a developing program, some form of procedure arises whereby these people will be paid for?

DEAN HAMILTON: In that case, first of all, we hope that patients will seek admission to our closed teaching units because of the resources I mentioned. When they have a fee attached to them we hope that some arrangement will develop as now obtains, where the fees collected from insured patients are put into a pool and they are used in a variety of ways; they are used to pay travelling expenses of the members of the teaching unit to go to meetings, to take courses, sometimes to pay for assistants, research assistants to help research. Sometimes a proportion of them are returned on



HAMILTON

9883

a pro rata basis to the members of the teaching unit but individual fees are not collected by the individual members of the teaching unit. Does this answer your question?

COMMISSIONER McCUTCHEON: And you would want that situation to continue?

DEAN HAMILTON: We wish that situation to continue. We still have the basic problem, however, of making certain and ensuring that our care and our facilities are the most attractive in the area.

THE CHAIRMAN: Ultimately that must be the situation?

DEAN HAMILTON: Yes.

COMMISSIONER VAN WART: Do you teach on these semi-private patients at all?

DEAN HAMILTON: It depends on the individual clinician. In some services in our teaching hospitals, private patients are used and semi-private patients but it is always by the clinician who is responsible for the particular private patient. In other words, the private patient would not be used by a variety of different clinicians, always by his own who will bring students.

COMMISSIONER VAN WART: If a plan comes into effect and the patient is in the ward then that physician loses his identity as a private physician to that patient?

DEAN HAMILTON: Yes.

COMMISSIONER FIRESTONE: Dean Hamilton, how is the operation of the hospital insurance program



Sharpe

9884

in existence in Ontario affecting the operations of the teaching hospitals at the University of Toronto? Would it be possible for you to give us an indication of a favourable effect, an adverse effect, if any such effect has been felt or is being felt?

DR. SHARPE: I would say that the Commission, the actual operation of the hospital as far as the Commission is concerned, we have no problem. As far as some of the availability of these special facilities, we have to make particular representation for it and sometimes we are not successful. I think it is a recognition of the fact that the teaching hospital has a special problem beyond that of a community hospital.

MR. WALLACE: The coming of the Commission and the coming of the insurance scheme has been of material assistance in our hospital because instead of spending our time worrying about money we are spending our time administering the hospital.

COMMISSIONER McCUTCHEON: You still had Dr. Sharpe's rider that there are additional facilities you would like to see available to the teaching units?

MR. WALLACE: Yes. The Commission have some yardsticks which are slightly punishing to those of us working in a little richer area.

COMMISSIONER McCUTCHEON: Their yardstick is not a full 36 inches?

MR. WALLACE: It is for some hospitals but not ours.

COMMISSIONER FIRESTONE: You have made



in excess of a certain amount, the operation of
the tariff is to be at the University of Toronto
would be possible for you to give us an indication
of a further effect, an adverse effect, if any such
effect is to be expected.

Mr. WILKINSON: I would say that the
Commission, the actual operation of the hospital as far
as the Commission is concerned, we have no problem. As
far as some of the availability of these special facilities,

we have to make further representation for it and
sometimes we are not successful. I think it is a
question of the fact that the teaching hospital has
a special position beyond that of a community hospital.

Mr. WILKINSON: The coming of the
Commission and the cost of the insurance before the
year of material assistance in our hospital because
instead of spending our time working about money we
are spending our time administering the hospital.

Mr. WILKINSON: You still
and you have a number of other additional facilities
as you would like to see available to the teaching

Mr. WILKINSON: Yes, the Commission
have some of the data which are already coming to

Mr. WILKINSON: What would be the effect of
which is not a lot of money

Mr. WILKINSON: It is for some special

for the year



Hamilton

9885

a general recommendation about the recognition of the teaching hospital in your report; can you spell out specifically what you had in mind that could be done to come to grips with this sort of problem that your colleagues have been mentioning to us?

DEAN HAMILTON: I think it means an amendment to the Hospital Insurance Act which defines different categories of hospitals now but it does not define a teaching hospital. I think until there is such a definition we do not feel that the special problem particularly related to teaching, providing the facilities to teach, the capital construction costs, the provision of teaching equipment, we do not think there is any possible way of attaining such a system until the Act is amended.

COMMISSIONER FIRESTONE: Would you feel by introducing this new definition it would solve your problems or is there something more required?

DEAN HAMILTON: More than that is required.

COMMISSIONER FIRESTONE: Could you elaborate on that?

DEAN HAMILTON: What is required over and beyond the definition of the hospital is the provision of the money, grants available, under two categories, capital cost, construction of facilities and, secondly, equipment.

COMMISSIONER FIRESTONE: Thank you.
Now, may I turn to page 13, paragraph 39 and I quote:

"The people in the lower income groups



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

A general recommendation about the recognition of the
... in your report, on the other hand
... which could be done
... to get a better program that your
... have been working on.

... I think it means an
... the ... insurance for which ...
... but it does not
... there is
... that the special
... related to teaching, providing
... the ...
... we do not
... a
... the ... is ...

... would you feel
... it would save your
...
... than that is

... Could you

... or that

... What is required over

... the ... is the provision
... under two categories,
... of ...

... and I ...
... in the ...



Janes

9886

in this area, and I suspect throughout the country, do not, in many instances, receive the minimum of dental care necessary for the maintenance of general health."

What evidence have you for such a statement?

DR. JANES: Well, I should think that briefly it is a long experience in hospital care and contact with large numbers of people, particularly those who come to the out-patient departments. These people, certainly in many instances, are gravely in need of dental care which there is no means, at the present time, of giving them.

COMMISSIONER FIRESTONE: Is your observation based on your experience that you have to turn large numbers of people away because you cannot provide them with medical care?

COMMISSIONER McCUTCHEON: Medical or dental?

COMMISSIONER FIRESTONE: I am sorry, dental care.

DR. JANES: The kind of dental care that is available is very limited in extent.

THE CHAIRMAN: That is in respect to teaching hospitals?

DEAN HAMILTON: Yes.

COMMISSIONER FIRESTONE: Is the answer to my question that because of the limited services available they have been turning a large number of people



...the report, and I suggest through-
 the country, or not, in many instances,
 to have the minimum of dental care
 necessary for the maintenance of
 dental health."

...that evidence has been for a state-

and.

...JAMES: Well, I should think that

...it is a long experience in hospital care and
 contact with large numbers of people, particularly those
 who come to the outpatient department. These people,
 certainly in very large numbers, and gravely in need of
 dental care which there is no means, at the present time,
 at being met.

...JAMES: Is your

...observation based on your experience that you have to
 turn large numbers of people away because you cannot
 provide them with dental care?

...JAMES McCUTCHON: Dental or

...dental.

...

...dental care.

...JAMES: The kind of dental care

...that is available is very limited in extent.

...JAMES: That is in respect to

...dental hospitals.

...JAMES: Yes.

...JAMES: The answer

...to my question this morning of the limited services
 available they have been turning a large number of people



Janes

9887

away that have come in for requests for attention in the dental field?

DR. JANES: Well, the dental care that is offered is very limited in extent; chiefly extraction and a very minimum of reconstructive work.

COMMISSIONER FIRESTONE: When you use the word "limited", you refer to the type of care?

DR. JANES: Yes, there is no means of financing it.

COMMISSIONER FIRESTONE: Is it also limited in the number of persons that can be attended to?

DR. JANES: Yes, it is.

COMMISSIONER FIRESTONE: Are you turning a large number of people away?

DR. JANES: My information in this direction comes from our dental clinic and they can only look after a very minimal number.

COMMISSIONER FIRESTONE: If people are turned away could they not go to an out-patient clinic in a general hospital and get the necessary care; an out-patient clinic in a general hospital?

DR. JANES: There are no out-patient dental clinics equipped beyond those of the teaching hospital. They are lacking in all hospitals and I sure the dentists will support me in that.



every day have come in for requests for attention in

the dental field.

Q. Now, then, the dental care that is offered is very limited in extent; chiefly extraction and a very minimum of reconstructive work.

A. Yes, sir.

Q. Now, when you use the word "limited", you refer to the type of care?

A. Yes, sir. There is no means of

financing it.

Q. Now, is it also

limited in the number of persons that can be attended to?

A. Yes, sir. The number of people that you can

attend to is very limited.

Q. Now, my information in this

information comes from our dental clinic and they can only look after a very minimal number.

Q. Now, if people are

turned away could they not go to an out-patient clinic

in a general hospital and get the necessary care; an

out-patient clinic in a general hospital?

A. Yes, sir. There are no out-patient

dental clinics equipped beyond those of the teaching

hospital. They are lacking in all hospitals and I am

sure the dentists will support me in that.



1
2
3
4 COMMISSIONER FIRESTONE: I take it
5 then if someone is turned away from the teaching hospital,
6 because-he has come to you to have his dental needs
7 looked after, he is turned away because you have not got
8 the room for him, there is no other place he can go. Is
9 that the point you are making, as far as the hospitals
are concerned?

10 DR. JANES: Not only have we not got
11 the room, we have no means of financing the care that he
12 would require.

13 COMMISSIONER FIRESTONE: Thank you
14 very much.

15 COMMISSIONER BALTZAN: Gentlemen, I
16 must compliment your Faculty of the University of Toronto
17 for your statement on Page 6, Paragraph 2, which is a very
18 clear-cut and broad-minded declaration of the inter-rela-
19 tionship of the teaching hospitals and the medical schools
20 of the University and the problems important to us, that
21 is because we had some other points of view elsewhere in
22 our hearings.

23 Turning to Page 1, you introduce a
24 modern concept, Page 1 of your argument, number 5: "In
25 the creation of a spirit of enquiry research is of prime
26 importance and no institution not engaging in research
27 can for long remain a first-rate centre of teaching. "
28 And the spirit is necessary for the best kind of teaching
29 hospitals. You submit that?

30 DEAN HAMILTON: Yes, sir.

COMMISSIONER BALTZAN: No one can
hardly disagree with you. My point is this, vis a vis



then if someone is removed away from the teaching hospital, because he has come to you to have his dental needs looked after, he is removed away because you have not got the room for him, there is no other place he can go, is that the point you are making, as far as the hospitals

Dr. J. H. B. : Not only have we not got the room, we have no means of financing the care that he would require.

very much.

COMMISSIONER BALTMAN: Gentlemen, I

trust compliment to the Faculty of the University of for your statement on Page 6, Paragraph 2, which is a very clear-cut and precise declaration of the inter-relationship of the teaching hospitals and the medical schools of the University and the problems important to us, that is because we had some other points of view elsewhere in our hearing.

Turning to Page 1, you introduce a new concept, Page 1 of your argument, number 1: "Action of a spirit of inquiry research is of prime importance and no institution not engaging in research can for long remain a first-class centre of teaching." And the spirit is necessary for the best kind of teaching hospitals. You submit that?

JOHN HAMILTON:
COMMISSIONER BALTMAN:

to reply disagree with you. My point is this, via a via



Hamilton 9890

our hospital insurance Diagnostic Act, we have heard things said across the country but continually there has been the emphasis on the reduction of cost for care in hospital, reduction of occupancy of beds in hospital and yet this is a necessary element in the kind of a hospital now, and in the future with an added expense, undoubtedly.

This added expense should then, you think, be separated from the cost of patient care, as a separate budget so it will not involve particularly the patient-care costs, which are always mounting.

DEAN HAMILTON: Yes, Dr. Baltzan.

COMMISSIONER BALTZAN: In other words, two accounts should be kept?

DEAN HAMILTON: Yes.

COMMISSIONER BALTZAN: And one is as important as the other, as far as promoting the type of hospital to fulfill the aims that you have in mind.

On page 5, the last paragraph: "Today no one would think of establishing a medical school apart from a university." And that is North America's concept and very rigidly adhered to. You are aware, I expect, that there are some countries where that does not obtain?

DEAN HAMILTON: It is true in some parts of the United States, Dr. Baltzan.

COMMISSIONER BALTZAN: Still in the United States?

DEAN HAMILTON: Yes, where the medical school is remote from the university. The medical school



Hamilton 9891

may be established remote from the University.

COMMISSIONER BALTZAN: I do not mean geographically.

DEAN HAMILTON: You mean total, yes, I know that this is quite true in Russia. It is true in South-east Asia and Thailand. As mentioned this morning I think it is also true in certain other countries in Europe?

COMMISSIONER BALTZAN: In some South-American countries. On Page 8, somewhere in the middle, and that has already been touched on, "Should there be universal insurance coverage there may be great pressure to allow every doctor the privilege of caring for patients in any area of the hospital." Including, of course, the specific area that you mentioned for teaching and that may be true. I heard your explanation that if it is sufficiently attractive then you will have an adequate number of patients for the purpose.

Have you had any legal advice as to whether any law could govern your proposition or would it be a matter of common understanding chiefly you are going to rely on, at least for the present?

DEAN HAMILTON: It is simply the by-laws of the hospital, the teaching hospital under the categories of attending physicians or under the category of staff.

There is one category of staff which has the right to admit patients and to treat patients in the teaching area. Perhaps Dr. Sharpe could answer that in more detail, and tell whether I am right or wrong.

DR. SHARPE: Well, in adding to what --

may be established between them the University.

COMMISSIONER BALLMAN: I do not mean

geographically.

I know that this is quite true in Russia. It is true in
South-east Asia and Thailand. I mentioned this morning
I think it is also true in certain other countries in

10:00

COMMISSIONER BALLMAN: In some South-

American countries. On page 8, somewhere in the middle,
and that has already been touched on, "Should there be
universal insurance coverage there may be great pressure
to allow every doctor the privilege of caring for patients
in any area of the hospital." Including, of course, the
specific and that you mentioned for teaching and that
may be true. I heard your explanation that it is
sufficiently attractive when you will have an adequate
number of patients for the purpose.
Have you had any legal advice as to

whether any law could govern your position or would it
be a matter of common understanding chiefly you are going
to rely on, at least for the present?

COMMISSIONER BALLMAN: It is simply the by-law

of the hospital, the teaching hospital under the category
of attending physicians or under the category of staff.

There is one category of staff which

has the right to admit patients and to treat patients in
the teaching area. I think Dr. Shapiro could answer that

in more detail, and tell whether I am right or wrong.

Dr. Shapiro: Well, in adding to what --



Sharpe 9892

COMMISSIONER BALTZAN: I am not asking this as a blocking agent. Only for clarification.

DR. SHARPE: I think here what you are asking can be answered by this: That the patients within that area, which is a segregated area, are in the care of the staff as a whole. This is a progressive care. A graduated care.

The medical student, the interne, the resident staff physician, the consultant. They are responsible for the treatment of the patient within the closed area.

COMMISSIONER BALTZAN: I understand that, sir. What bothers me is separation from his own physician. The recommendation on a referral basis for this person's particular service while in hospital, otherwise he could take him in a section where he might have an appointment and care for the patient himself.

DR. SHARPE: That is quite true, Dr. Baltzan. The same situation exists now and has in the teaching hospitals as long as, I suppose, there have been teaching hospitals with closed teaching wards which in this centre goes back to the last century.

COMMISSIONER BALTZAN: Mainly of the indigent category, as the Chairman has mentioned.

DR. SHARPE: They were but they have been referred by other physicians to that hospital. Just as they are now. They may be referred to a particular physician.

COMMISSIONER BALTZAN: I understand. I posed this only as a matter that would probably have to



Hamilton 9893

be cleared further and future experience will show the way clear.

Thank you.

COMMISSIONER GIRARD: Dean Hamilton, on Page 20 under nursing, Paragraph 62, you said: "A survey of these departments leads one to believe that the cost is greater but not significantly greater than that of any hospital running an efficient school of nursing."

You are referring to the cost of nursing in teaching hospitals. Has any study been made of this? Did you get your answers from any study or is it general opinion?

DEAN HAMILTON: I would ask Dr. Janes who obtained this information, Miss Girard.

DR. JANES: The statement is made on the basis of answers to questions submitted to the nursing departments of the four teaching hospitals, the four major teaching hospitals.

COMMISSIONER GIRARD: Dr. Janes, was this looked at from the point of view of the graduate nursing staff as well as the student, because it could be affecting the graduate nursing staff as much as, if not more than the students?

You refer here only to schools of nursing. I think this is the opinion that in the hospital where a great deal of teaching is done, it does affect the nursing quantity; sometimes maybe the quality of nursing.

DR. JANES: I might say that ---



is obtained? Order and future experience will show the

COMMISSIONER OF LABOR: Dean Hamilton,

on page 20 under heading, paragraph 62, you said: "A survey of these departments leads one to believe that it is greater but not significantly greater than that of any hospital running an efficient school of nursing."

You are referring to the cost of nursing in teaching hospitals. Has any study been made of this? Did you get your answers from any study or is it a general opinion?

DEAN HAMILTON: I would ask Dr. James who obtained this information, Miss Girard.

DR. JAMES: The statement is made on the basis of answers to questions submitted to the nursing departments of the four teaching hospitals, the four major teaching hospitals.

This looked at from one point of view of the graduate nursing staff as well as the student, because it could be affecting the graduate nursing staff as much as, if not more than the student.

You refer more only to schools of nursing. I think this is the opinion that in the hospitals there a great deal of teaching is done, it does affect the nursing staff; sometimes more the quality of



Janes 9894

COMMISSIONER GIRARD: And not just from the school point of view.

DR. JANES: ---I was surprised that more emphasis was not placed upon this point by the various nursing services, but I think that perhaps the feeling was that a hospital that was running a school of nursing, and running an efficient school would require most of the facilities that are available in the teaching hospitals.

COMMISSIONER GIRARD: But it may require more personnel?

DR. JANES: More personnel.

COMMISSIONER GIRARD: Because it is a teaching hospital.

DR. JANES: Yes.

COMMISSIONER GIRARD: Not only facilities, it would not only affect the school, also affect the graduate nursing staff and the reasons then that we give here for the limitation of people to the school are not really affected by teaching hospitals more than any others?

DR. JANES: No.

COMMISSIONER GIRARD: It said here that the number of nurses being trained was limited by accommodation, educational requirements, long period of time without income. That would have no relationship whether it was a teaching hospital or a non-teaching hospital.

DR. JANES: No, it's related to the whole problem of attracting girls to train as nurses and again, the replies --- those are based on replies received



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

COMMISSIONER GIRARD: And not just

from the school point of view.

MR. JAMES: ---I was surprised that

some emphasis was not placed upon this point by the
various nursing services, but I think that perhaps the
feeling was that a hospital that was running a school of
nursing, and running an efficient school would require
most of the facilities that are available in the teaching

COMMISSIONER GIRARD: But it may

require more personnel?

MR. JAMES: More personnel.

COMMISSIONER GIRARD: Because it is

a teaching hospital.

MR. JAMES: Yes.

COMMISSIONER GIRARD: Not only facilities

also, it would not only affect the school, also affect
the graduate nursing staff and the reasons then that we
give here for the limitation of people to the school are
not really affected by teaching hospitals more than any

others?

MR. JAMES: No.

COMMISSIONER GIRARD: It said here that

the number of nurses being trained was limited by economic

action, educational requirements, long period of time

without income. That would have no relationship whether

it was a teaching hospital or a non-teaching hospital.

MR. JAMES: No, it's related to the

whole problem of attracting girls to train as nurses and

again, the replies --- those are based on replies received



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Janes 9895

from the superintendent of these schools. Those replies surprised me that this would obtain from the questionnaire.

COMMISSIONER GIRARD: Thank you very much.

THE CHAIRMAN: Thank you very much, gentlemen.

THE SECRETARY: The Faculty of Dentistry, be known as Exhibit 272.

Dr. R.G. Ellis will introduce his group.

James 3755

from the Department of these schools. These results
indicated me that this would obtain from the question-

THE CLINICAL: Thank you very much.

THE CLINICAL: Thank you very much.

THE CLINICAL: The Faculty of Dentistry

is known as Exhibit 375.

13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30



---EXHIBIT NO. 272: Submission by the Faculty
Dentistry.

S U B M I S S I O N O F
THE FACULTY OF DENTISTRY, UNIVERSITY OF TORONTO

APPEARANCES:

DR. R.G. ELLIS,
PROF. G. NIKIFORUK
PROF. R.M. GRAINGER

DEAN ELLIS, Mr. Chairman, Members of
the Commission, I would like to introduce to you first
of all, Dr. Gordon Nikiforuk, Professor of Preventive
Dentistry and Chairman of our Division in Dental Research.
On my left Dr. Robert Grainger Professor of Dentistry Bio-
metrics. Statistical Expert on the Faculty as it relates
to Dentistry.

Mr. Chairman, I am very happy to have
this opportunity of presenting to the Commission the brief
that has been prepared on behalf of the Faculty of Dentis-
try and Dr. Nikiforuk and Dr. Grainger will help me on
any questions that arise.

We state in the summary of conclusions
and recommendations that our brief has been limited, as
far as possible, to matters pertaining to dental education
and our summary and conclusions include seven rather
broad general areas. First of all facilities for dental
education, and then staff problems and then support for
the dental school and students and the importance of
dental health research and the mass of auxiliary personnel



Ellis 9897

and their training and the need for close association with the dental schools, between the dental schools and teaching hospitals.

The statements which we have included in the conclusions and recommendations have been expanded in the main part of the report, and with your permission, Mr. Chairman, I would like to read the summary of conclusions, following which we would be prepared to try and answer questions.

The first page of the brief, the summary of conclusions and recommendations starts with one which relates to educational facilities. I made a statement here that to maintain the present ratio of dentists to the population in Ontario through to 1980, it will be necessary to establish a new dental school of dentistry in the Province of Ontario.

Planning and construction schedules should provide for the graduating of this class of sixty students by 1968.

This number of sixty students is rather interesting. There was no collusion between the medical brief and the dental brief. This does represent an estimated percentage of increase of approximately 50% over the present output of the one dental school in Ontario.

The capital cost of this project would be not less than \$4,000,000.00.

THE CHAIRMAN: On that, have you any recommendation as to the location? I am not necessarily appointing a City, but are you thinking of something like



11111

11111

...and the need for close collaboration
with the dental schools and
teaching hospitals.

The statements which we have indicated
in the conclusions and recommendations have been discussed
in the main part of the report, and with your permission,
Mr. Chairman, I would like to read the summary of conclu-
sions, not being which we would be prepared to try and

The first part of the paper, the

...of the situation and recommendations starts with one
which is based on the existing facilities. I made a
statement some time ago to maintain the present ratio of
dentists to the population in Ontario through to 1980,
it will be necessary to establish a new dental school or
extension of the Province of Ontario.

...and constant schedules

...the graduating of this class of six
...by the

...of sixty students is

...There was no collision between the
...the dental school. This does represent
...increase of approximately 10%
...the present output of the dental school in

...of this project will

...of the

...On that, have you

...to the location? I am not necessary
...but are you thinking of something like



Ellis . . . 9898

Toronto or elsewhere?

DEAN ELLIS: Outside of Toronto. Very definitely outside of Toronto. It must be in an area that can support a dental clinic and an area where there are sufficient dentists to provide part-time teaching staff. I think this is fairly clear. I think there have been two or three particular spots, but certainly outside of Toronto.

COMMISSIONER McCUTCHEON: In a university centre, of course?

DEAN ELLIS: In a university centre, of course.

These funds should be provided on a matching-grant basis, shared by the Provincial and Federal Governments.

The second recommendation deals with teachers and research personnel.

(a) A long-range program for training full-time teaching and research personnel is urgently needed.

(b) Generous Fellowships are essential to encourage carefully screened applicants who have demonstrated aptitude for a full-time University career, is what we have in mind.

(c) The Ontario needs in this respect would amount to \$50,000.00 to \$75,000.00 per year.

And here we are thinking at the moment with a new school projected, then these needs may rise. The Ontario needs



Page 1

Department of Education

Very much interested in the work of the Department.

It must be in an area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

at the time of the

Department of Education

There is a high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

of course

There is a high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

of course

There is a high concentration of people in the area where there is a high concentration of people.

A high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.

There is a high concentration of people in the area where there is a high concentration of people.



1
2 in this respect would amount to \$50,000.00 to \$75,000.00
3 a year. In a later part of the brief we detail them on
4 a five-year period and the total over a five-year period
5 is about \$330,000.00.
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30



in the year 1911 amount to \$53,511.00 to \$17,000.00
A year. In a year part of the hotel we get 11.5 in
a five-year period and the total over a five-year period
is about \$1,100,000.00

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100



- 1
2
3
4 (d) The national character of this project,
5 because of the fact that the product of a
6 teacher training program is important, not
7 only to this School but to all major dental
8 schools in Canada, suggests that the major
9 responsibility rests with the Federal
10 Government.

11 R.3 Need for Support for Faculty Clinic:

- 12 (a) It is recommended that Universities maintaining
13 a dental school, should receive a grant from
14 public funds to offset the cost of operating
15 the extensive out patient clinic.
16 (b) An annual grant of \$1,000.00 for each student
17 registered in the Faculty is necessary to
18 maintain these clinical facilities for teaching
19 dental students, and in this connection we
20 mean each of the four years, not just the
21 clinical years.
22 (c) The municipalities in which these clinical
23 facilities are located should share the costs of
24 this community service with respective
25 Provincial Governments, and I might stress
26 that this clinic which we operate for teaching
27 purposes does provide a very important social
28 service in the community in which it operates.

29 R.4 Need for Student Aid:

- 30 (a) Promising students from low income families
should be encouraged to seek dentistry as a
career.
(b) Many such students reside in the rural districts



Ellis

9900

and small communities.

(c) It is recommended that bursaries and loan funds be provided so that more students in these categories who seek admission to the Faculty of Dentistry might be assured of substantial financial assistance, providing they maintain satisfactory standing each year.

(d) Dominion-Provincial bursaries should be greatly increased.

(e) Loan funds created by contributions from governments and the profession are required.

R.5 Need for Extending Public Education in Dental Health:

(a) Dental disease affects Canadians almost universally, and constitutes a major health and economic problem.

(b) Education is necessary to impress upon the individual his personal responsibility in the control of dental disease. This point is one that we think needs a good deal of emphasis.

(c) Financial backing is needed for a comprehensive dental health education program.

R.6 Need for expansion of Dental Research:

(a) Research is vital to the future reduction of dental disease.

(b) It is recommended that greatly increased funds be made available for training research personnel and for the support of projects.

(c) It is estimated by 1975 the current expenditures for dental research in Canada must be



and small communities,

(a) It is recommended that priorities and loan funds

be provided so that more students in these categories who seek admission to the Faculty of Dentistry will be assured of adequate financial assistance, providing they maintain

(b) Non-profit educational business should be

greatly increased.

(c) Loan funds created by contributions from

governments and the profession are required.

Need for Expanding Public Education in

Dental Health

(a) Dental disease affects Canadians almost

universally, and constitutes a major health

and economic problem.

(b) Education is necessary to impress upon the

individual his personal responsibility in the

control of dental disease. This point is one

that we think needs a good deal of emphasis.

(c) Financial backing is needed for a comprehensive

dental health education program.

Need for Expansion of Dental Research

(a) Research is vital to the future reduction of

dental disease.

(b) It is recommended that greatly increased funds

be made available for training research

personnel and for the support of projects.

(c) It is estimated by 1975 the current expendi-

ture for dental research in Canada must be



Ellis

9901

increased twelve-fold from the present
\$250,000. a year to \$3,000,000.00 per year.

- (d) The sources of research funds include
government, industry and private individuals.

The next four recommendations relate
to auxiliary personnel.

R.7 Need for More Dental Hygienists:

- (a) The dental hygienist plays an increasingly
useful role in the dental health team.
- (b) Dental hygienists are in very short supply,
hence adequate training facilities should be
part of all Canadian dental schools. I think
this past year only one school has been training
dental hygiene students, the University of
Toronto. Two additional schools have
introduced this training program during the
past session.
- (c) Financial assistance should be available for
dental hygiene students.

R.8 Need for Dental Assistant Training Courses:

- (a) The establishment of courses for dental
assistants is essential to the overall dental
manpower requirements.
- (b) It is recommended that courses for dental
assistants be established in the science,
technology and trades branch of the Secondary
Schools of Ontario and of Vocational Schools.
I might say that since this program, or
sentence was written, there has been a develop-
ment in the Scarborough district, in which there



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

...the ... from the ...

...a year ...

(1) The ...

...government, ...

...the ...

...to ...

...the ...

(2) The ...

...in the ...

(3) ...

...should ...

...I think ...

...the ...

...the ...

...the ...

...the ...

...the ...

(4) ...

...the ...

...the ...

(5) ...

...the ...

...the ...

(6) ...

...the ...

...the ...

...the ...

...the ...

...the ...

...the ...



is a training program contemplated for dental assistants in the vocational stream of secondary education in that municipality.

R.9 Need for Training Dental Students in the

Use of Assistants:

- (a) The productivity of the dental profession can be significantly increased by the more efficient utilization of the dental assistant.
- (b) Dental schools must study and experiment in the most effective procedures in teaching dental students to utilize the services of the dental assistant.
- (c) It is estimated that \$50,000.00 to \$60,000.00 per year will be required for an experimental period of five years.

R.10 Need to Study Extension of Duties of

Auxiliary Personnel:

- (a) No new types of auxiliary personnel should be introduced into the practice of dentistry until the profession has fully explored the effect of the maximum utilization of the services of the dental hygienist and the dental assistant.
- (b) Experimentation should be conducted in dental schools to develop ways and means of broadening the scope of service of the dental hygienist under the supervision of the dentist.

R.11 Need for Closer Association Between Dental

Schools and Teaching Hospitals:

- (a) A much closer association between the dental

3000

1944

is a program designed for dental
education in the vocational field of
dentistry education in the dental field.

Need for

Need for

(a) The necessity of the dental profession can
be significantly increased by the more
effective utilization of the dental assistant.
(b) Dental schools must study and experiment in
the most effective procedures in teaching
dental students to utilize the services of the
dental assistant.

(c) It is estimated that \$50,000.00 to \$60,000.00
per year will be required for an experimental
period of five years.

Need for a Study of the Effect of

Effect of

(a) The use of auxiliary personnel should be
introduced into the practice of dentistry
until the profession has fully explored the
effect of the maximum utilization of the
services of the dental assistant and the dental
assistant.

(b) Investigation should be conducted in dental
schools to develop ways and means of promoting
the scope of service of the dental assistant
under the supervision of the dentist.

Need for an Association between Dental

School and Dental Assistant

(a) A study of the association between the dental



Ellis

9903

1
2
3
4 schools and the teaching hospitals would
5 ultimately be reflected in improved health
6 services for the people of Canada.

7 (b) The agency or agencies responsible for
8 hospital administration and financing, are
9 urged to recognize that dental services are an
10 integral part of the provision of all health
11 care services.

12 (c) Dental departments should be created in
13 hospitals which do not already possess them,
14 and in most instances dental departments which
15 do exist need to be broadly expanded.

16 (d) In addition to teaching, out patient dental
17 departments in hospitals could provide much
18 needed services for people with marginal
19 incomes. This point was discussed very
20 recently by this Commission.

21 (3) Dentists appointed to the professional staffs
22 of such hospitals should be permitted to render
23 their professional services under by-laws and
24 regulations which give full cognizance to their
25 education, training and licensure.

26 Mr. Chairman, we would be very happy
27 to try and elaborate on any of these points which have
28 not been covered in the main body of the brief.

29 THE CHAIRMAN: Well thank you very
30 much, Dean Ellis. A study of the brief and of the
information given shows that you have attempted in each
case to state in a lucid way the explanation of these
various recommendations, but if I may refer to the



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

...and the ...
...in ...
...of ...

(1) The ... responsible for
... and ...
... dental services are an
integral part of the provision of all health

(2) ... should be created in
hospitals which do not already possess them,
and in ... dental departments which
do exist need to be broadly expanded.

(3) In addition to teaching, the patient dental
... could provide much
needed ... for people with manual
... This work was discussed very
... in the ...

(4) ... to the professional status
of ... should be permitted to render
their professional services under by-laws and
regulations which give full cognizance to their
education, training and experience.

Mr. Chairman, we would be very happy
to try and ... on any of these points which have
not been covered in the main body of the paper.

Mr. Chairman: Well thank you very

much, ... of the ...
... that you have attempted in each
case to ... the explanation of these
various recommendations, but if I may refer to the



1
2
3 recommendation number 10, at the foot of page 4, where
4 you recommend no new types of auxiliary personnel.

5 You don't name anybody in that. Have
6 you any specific grouping, or group? I don't want to
7 put this in the way of an embarrassing situation, but
8 it has been stressed from one end of Canada to the
9 other that there is a great shortage of dentists. We
10 were told that there was not much use in giving serious
11 consideration to a comprehensive dental program, because
12 there were not enough dentists who could man such a
13 program if one was proposed. And further, that there
14 was really no immediate relief in sight. That this is
15 a matter of quite a few years before the situation could
16 be improved, where anything beyond the program for
children up to 16 could be thought of.

17 In that situation does the Dental
18 School see that it might help out by training school
19 nurses say in dentistry, so that they might be used as
20 they are used in New Zealand for instance in the
21 elementary school system there, and in the limited degree
22 to which they are used, or also with the dentures,
23 whatever name they might be called, as personnel who
24 might not do as good a job as fully trained dentists,
25 but who would still fill what is a very real need at
the present time?

26 DEAN ELLIS: Well, Mr. Chairman, in
27 reply to that comment and question, this is exactly
28 what we have in mind when we make this statement, that
29 these people should not be trained in Canada, or
30 contemplated at the present time, because we believe very



Ellis

9905

1
2
3
4 strongly that the better integration of the two types
5 of office personnel that we have at the present time,
6 the dental hygienist and the dental assistant, could
7 very markedly increase the productivity of the dental
8 offices. There have been experiments done on this, and
9 the experiments would lead one to believe that without
10 putting the dentist into a seven ring circus in his
11 own office by having so many people chasing around him,
12 that his productivity could be increased.

13 There are figures out of surveys that
14 have been done to indicate that a single dentist with
15 two operatories, two offices, with adequate personnel,
16 say a hygienist and perhaps two assistants, that his
17 productivity can be increased by twice his normal
18 productivity if he were working alone, and these areas
19 have not been fully explored.

20 I am here to admit that we have failed
21 completely in the Dental School to train the new
22 dentist, the student dentist how to work and get the
23 most efficient service out of the chairside assistant,
24 and I know there is concern in the minds of some members
25 of the profession that what we think of here is a
26 seven ring circus with people chasing all around the
27 dentist's office, but with the proper integration and
28 training of these people, we believe that a very great
29 increase in the productivity of the dental profession
30 can be effected by staff that we already know. We know
their capabilities, and what can be done.

31 Personally, I had the experience
32 twelve years ago of spending some time in New Zealand,



1
2
3 and I know the New Zealand Dental Nursing Scheme very
4 well personally, and I am here to say that I don't
5 believe this is the answer. These girls certainly can
6 be trained to do certain limited things well but the
7 wastage of personnel in that program, if you want to
8 call marriage wastage, and some people would no doubt
9 disagree, but the wastage is very great, and the cost
10 of training these people for a period of an average of
11 four or five years of service is just as great as
12 providing the extra facilities for dental schools, and
training more dentists.

13 And this is our belief, that there
14 should be at least a new dental school in the Province
15 of Ontario, and others in Canada, probably two or three,
16 and that, coupled with the program of more efficient
17 use and training of dental students, dental hygienists,
18 and the dental assistants in a health team, that the
19 product of a dental office can be tremendously increased,
20 without getting into new types which may be very difficult
to direct and control.

21 THE CHAIRMAN: You told us of certain
22 experiments that are being made. I don't know if you
23 are in a position to give us the benefit of those now,
24 but if not, if it could be made available to us it might
well be of some considerable assistance.

25 DEAN ELLIS: They are experiments that
26 have been done in the United States, and are reported
27 in the United States dental literature. I am sure they
28 are in this volume of the Survey of Dentistry which has
29 just been produced by the American Education Council.
30



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

and I know that the National Education Association very
well knows that, and I have to say that I don't
believe this is the way. These things certainly are
essential to the health of the nation well but the
question of whether or not they are, if you want to
know, is a question, and some people would say no, some
say yes, but the fact is, the very great, and the great
of training that we have a period of an average of
four or five years of training is that as great as
would be the other, and for dental schools, and
the fact is our belief, that there
should be at least a two-year school in the Province
of Ontario, and others in Canada, probably two or three,
and that, which will the program of more efficient
and training of the dentists, dental hygienists,
and the dental schools in a number of them, that the
question of dental schools can be considerably increased,
without having any more which may be very difficult
to think and practice.
The National Education Association has said as of course
experience that and being made. I don't know if you
have a position as to the benefit of these now,
but if not, it is a question as to whether it is right
to have some dental schools and others.
The fact is that they are experiments that
have been made in the United States, and the report of
the National Education Association. I am sure they
are a good voice of the nation of dentistry which has
been made in the National Education Council.



1
2
3 We have taken them directly from this.

4 THE CHAIRMAN: I am sure our research
5 staff can dig them out.

6 COMMISSIONER STRACHAN: I have a few
7 questions which relate particularly to the recommendations,
8 and if I may I will refer to the last recommendation,
9 11(c), regarding the dental departments in hospitals,
10 and the reason I am asking this one first is because
11 I might well have asked the former group who appeared
12 before us, and my question would be, what progress has
13 been made in the establishment of dental clinics in
teaching and other general hospitals in Ontario?

14 DEAN ELLIS: In the teaching hospitals
15 in this area, the Toronto General Hospital has a dental
16 service which has been established for some years. We
17 do have a dental intern there, or two, year by year.
18 The facilities are available for teaching purposes, but
19 this is pretty much the limit insofar as the use of
20 dental services in hospitals for teaching purposes.
21
22 -
23
24
25
26
27 -
28
29
30



1911

1

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO



Ellis

9908

The other hospitals in this area have dental departments or dental services, but they are limited, as has been indicated already by the former group, to very definite emergency operations.

COMMISSIONER STRACHAN: Are you referring, Dean Ellis, to the other seven teaching hospitals?

DEAN ELLIS: Yes, I think ultimately this would be our hope, our objective, that students, particularly in their graduating year, would get more experience in dental service in dental hospitals and we must think in terms of getting first in this particular area.

COMMISSIONER STRACHAN: Are there dental clinics in any of the other seven?

DEAN ELLIS: Yes, I wouldn't want to say in all of them, but certainly in many of them.

COMMISSIONER STRACHAN: And progress is being made, you feel, towards dental teaching in all?

DEAN ELLIS: I would say within the last year, 18 months, there has been tremendous progress made and we are very hopeful this is going to continue. At the moment it looks very good.

COMMISSIONER STRACHAN: Might this create a trend towards the establishment of more adequate dental clinics in other general hospitals?

DEAN ELLIS: I would think this would be the trend. It is hard to predict. There are many factors operating that make that very difficult to foretell.

COMMISSIONER STRACHAN: Coming back to Recommendation No. 2; how are the dental teachers



1111

The other hospital in this area is

and it is a very good one, but they are

not as well equipped as the other

two, and they are not as good as

the other two. Are you referring

to the other two? Never in the hospital?

This is a very good one, but they are

not as well equipped as the other

two, and they are not as good as

the other two. Are you referring

to the other two? Never in the hospital?

Yes, I wouldn't want to

go to the other two, but they are

not as well equipped as the other

two, and they are not as good as

the other two. Are you referring

to the other two? Never in the hospital?

Yes, I wouldn't want to

go to the other two, but they are

not as well equipped as the other

two, and they are not as good as

the other two. Are you referring

to the other two? Never in the hospital?

Yes, I wouldn't want to

go to the other two, but they are



Ellis

9909

recruited and trained and what are your problems associated with recruitment of teachers for dental schools?

DEAN ELLIS: Mr. Chairman and members of the Commission, this is a question that perhaps is a very serious question in relation to the operation of dental schools. By custom, in the past, dental teachers, a few dental teachers, men who are dedicated to this type of service, and I have two of them right here, that have indicated interest. We felt that they had the aptitude and ability in this field, and they have arranged for their own post-graduate and fellowship training. Each of these men I have with me have had two years following graduation in dentistry for this specific purpose. They have got their training in most instances at their own expense. There are only a limited number of people who are dedicated and willing to spend time to get training for a future in teaching when they could, perhaps, take a similar length of training beyond graduation in a specialty field and know very well they could go out as specialists at the end of the two-year period of training and probably earn twice as much as they are earning today.

This, gentlemen, is one great limitation, interesting sufficient people who are interested in full-time university teaching careers and assuring them if they take the time and make the effort and get the education that there is a post available to them that will prove lucrative, at least on a comparable basis to what their confreres could earn out in the specialty area.



Ellis

9910

We have been limited and forced to increase the number of part-time teachers. It is extremely hard to operate a dental school with part-time teachers. We have 108 part-time teachers on our staff and about 15 full-time. 65% of the teaching load, or thereabouts, is carried by part-time teachers whose prime interest is their practice, but they are dedicated to subsidizing dental education, because that is about what they are doing, just as they are in the Faculty of Medicine, subsidizing dental education by giving time at a very nominal stipend. These are the limitations.

We have lots of men who have the ability but it hasn't been attractive enough unless they are dedicated in the first instance. They are not likely to undertake a full-time career in this field.

COMMISSIONER STRACHAN: You have suggested somewhere in this brief that the proportion should be reversed, 65% full-time and 35% part-time.

DEAN ELLIS: For 10 years I have been including in recommendations to the university administration that our teaching load should be carried 60% full-time and 40% part-time. We have made virtually no progress, for financial reasons.

COMMISSIONER STRACHAN: Thank you, Dean Ellis. Referring to Recommendation 3, 3b, an annual grant of \$1,000 for each student registered in the Faculty of Dentistry is necessary to maintain the clinical facilities for teaching dental students. Is any of this money being supplied at the present time?

DEAN ELLIS: It is not being supplied



the same time, I would like to say

that the purpose of this meeting is to

extend the time to the students to

prepare for the time when they will

be in the position of having to

prepare for the time when they will

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to

be in the position of having to



Ellis

9911

1
2
3 for this purpose, Dr. Strachan. It is coming indirectly
4 by way of the university allocation to the Faculty of
5 Dentistry. I think it might be of interest to the
6 Commission to know we operate this very large dental
7 clinic for teaching purposes. It has a capacity of 120
8 students in the graduating class. These facilities -
9 to operate the facilities to train the dental students
10 in the clinical field are costing the university at
11 the present time somewhere in the neighbourhood of \$450,000
12 to \$480,000. This is before we start to teach the
13 students. These are for personnel that are needed to
14 help and assist operate this clinic. They have no part
15 in the teaching. It is people such as nurses; we have
16 a staff of nearly 40 staff nurses, and dental assistants,
17 a very large staff of technicians, secretarial and admini-
18 strative people.

18 These things and the maintenance of
19 the clinical facilities which are there for the purpose
20 of teaching, and does provide some service to the public,
21 is a cost in this range of \$450,000 to \$480,000 a year.
22 These facilities, if the comparison is not odious, in
23 the Faculty of Medicine, of course, are provided by the
24 hospitals.

25 The university has to provide an equiva-
26 lent to the hospital facilities for training medical
27 students, in the form of this extensive clinic for
28 training dental students. This is one of the heavy
29 burdens on the cost of dental education.

30 COMMISSIONER STRACHAN: Where do you
suggest this annual grant of \$1,000 for each student



Ellis

9912

should come from?

DEAN ELLIS: Well, it is suggested in the brief that the community has a responsibility in this because the service is to the community and the province has a responsibility in it because many of our patients are coming to us from areas outlying this community. Today we have patients coming 100 miles to get services at this clinic where they have needs of a special nature.

COMMISSIONER STRACHAN: Is there any possibility of receiving any help from the community in this respect?

DEAN ELLIS: To my knowledge there has never been any approach or offer.

COMMISSIONER STRACHAN: Thank you, Dean Ellis. Let us turn to Recommendation 4. Has there been a shortage of suitable applicants seeking admission to the study of dentistry? If there is or has been a shortage, is there any improvement in the situation and how can this situation be improved? What is being done to recruit the dental students?

DEAN ELLIS: Mr. Chairman, if I may ask Dr. Grainger to handle this. Dr. Grainger is dealing with our recruitment, our handling of new students and he will answer this question better than I.

DR. GRAINGER: Gentlemen, in terms of numbers the number of applications to the Dental College have been decreasing for some years until, in 1959, 1961, in that area there was scarcely enough to fill the class. In fact, of 102 applications which were received, fully-documented, in 1959-1960, 96 were accepted. That meant



Grainger

9913

very little selection was going on. However, in 1961, in the winter, the Ontario Dental Association, in co-operation with the Canadian Dental Association, launched a recruitment drive and they appointed a committee to look after this recruitment drive.

Local dentists in many of the outlying communities where it was mentioned we find students are not coming from; for instance, up in the Ottawa Valley, areas out of big municipalities, local dentists would go to the high schools on their own. They would, in their own cars, drive dental students down to the dental faculty and try and interest them in a career.

In many of these communities busloads of students have been brought down. As a result of this last year we had double the number of applications available and scholastic quality of these students was tremendously increased. This recruitment drive had a considerable effect on dental applications. We are sure there are enough good students in Ontario if we can get to them.

That only raises one question, but I am not sure we ourselves can answer: it does not seem quite right for the university to be, in any way, in the position of going out and recruiting students for itself which it may, in turn, have to reject. It should be done by some health agency.

DEAN ELLIS: I would like to add one comment, Dr. Strachan. We have over 400 applications at this moment for the class that will enroll in September this year. That number of 400 will go down to probably



very little selection was going on. However, in 1951, in the winter, the Ontario Dental Association, in co-operation with the Canadian Dental Association, launched a recruitment drive and they appointed a committee to look after this recruitment drive.

Local dentists in many of the outlying communities where it was mentioned we find students are not coming from; for instance, up in the Ottawa Valley, areas out of big municipalities, local dentists would go to the high schools on their own. They would, in their own cars, drive dental students down to the dental faculty and try and interest them in a career.

In many of these communities because of students have been brought down. As a result of this last year we had double the number of applications available; and academic quality of these students was tremendously increased. This recruitment drive had a considerable effect on dental applications. We are sure there are enough good students in Ontario if we can get to them.

That only raises one question, but I am not sure we ourselves can answer: it does not seem quite right for the university to be, in any way, in the position of going out and recruiting students for itself which is, in turn, have to recruit. It should be done by some health agency.

Dr. H. H. H. I would like to add one comment, Dr. H. H. H. have over 400 applications at this moment for the class that will enroll in September this year. That number of 400 will go down to probably



Ellis

9914

250 qualified applicants, but of that 250 we will be in a position to accept only 124. This raises and further emphasizes the point there are sufficient applicants now to fill another dental school in Ontario.

COMMISSIONER STRACHAN: Thank you, Dean Ellis. That is a very fine observation. Coming to Recommendation 5 in paragraph b, you indicate that education is necessary to impress upon the individual his responsibility in the prevention of dental disease. Could you tell us, or suggest, how education to the public could reduce the high incidence of dental disease?

DEAN ELLIS: I will ask Dr. Nikiforuk to answer that question.

DR. NIKIFORUK: Gentlemen, in some ways the very dilemma of our problem arises with public education in dental health. The nature of dental disease is such that it affects almost every man, woman and child in this country. The unfortunate aspect of this is that most of it, at least in relation to tooth decay, is preventable. That is why I use the word "dilemma".

In some ways one feels it is almost analogous to have a vaccination program for a certain ailment and yet have difficulty in having the people avail themselves of this preventive measure. We feel this is a very important area, and there is evidence that education would very significantly influence the rate of dental disease.

Some of the studies in the City of Toronto, Riverdale and the County of Wellington, emphasize that a very vigorous educational program can do much to



Nikiforuk

9915

1
2
3 reduce dental disease. I think this is a very important
4 aspect in terms of prevention. I could also cite another
5 example: in Sweden, the Government was very concerned
6 with the aspect of reducing dental disease through a
7 definite program. They commissioned the Royal College
8 of Dentists, the Royal Dental School, to study aspects
9 of Swedish diets that could be implemented on a broad
10 program and as well introduced a study that lasted many
11 years and cost the Swedish Government a lot of money.
12 It is available to many parts of the world now.

13 This project has been very significant
14 in reducing dental disease in the country. I feel that
15 this dilemma of being able to prevent disease, if only
16 we could get the people to implement the preventive
17 measures, is a very important one and lies in the dental
18 field of public education in dental health.

19 COMMISSIONER McCUTCHEON: You haven't
20 been successful in getting implementation of fluoridation?

21 DR. NIKIFORUK: We haven't been too
22 successful.

23 COMMISSIONER STRACHAN: I was going to
24 refer to that later. When I realized this brief pertains
25 to education in dentistry, I am sure my fellow Commis-
26 sioners would be very disappointed if I didn't ask you
27 your attitude towards fluoridation, fluoridation of
28 communal water supplies.

29 DEAN ELLIS: My only comment, Dr.
30 Strachan, is our Faculty, in 1955, prepared what we
thought was a fairly strong resolution in favour of
fluoridation of communal water supplies. For any



...dental disease. I think this is a very important
aspect of dental hygiene. I could also also see
extension in dental hygiene. The government was very concerned
with the aspect of dental disease through a
national program. They commissioned the Royal College
of Dentists, the Royal Dental School, to study dental
disease which was then reported on a 1966
program and as a result included a study that indicated
years and cost the dental government a lot of money.
It is available to many parts of the world now.

This project has been very significant
in reducing dental disease in the country. I feel that
it is difficult to bring about to prevent disease if only
we could get the people to make use of the prevention
program, as a very important one and lies in the dental
field of public education in dental health.

...dental health. You haven't
been successful in getting the prevention of dental disease
...dental health. You haven't been too
successful.

I was going to
refer to the fact that I feel that the dental
disease is a very important one and lies in the dental
field of public education in dental health. I feel that
it is difficult to bring about to prevent disease if only
we could get the people to make use of the prevention
program, as a very important one and lies in the dental
field of public education in dental health.

...dental health. You haven't
been successful in getting the prevention of dental disease
...dental health. You haven't been too
successful.



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Ellis

9916

further comment on that I would turn to Dr. Nikiforuk.

DR. NIKIFORUK: I consider fluoridation not a very controversial subject from a scientific standpoint. The evidence relating to its safety and effectiveness is overwhelming. This is why, in my earlier remarks, I said the situation is almost analogous to having a vaccination program for disease and not being able to get the people to avail themselves of such a significant preventive measure.



1
2
3
4 I believe public education is certainly one way of
5 doing this. I feel that in the general area of dental
6 health people must learn to help themselves more than
7 they have in the past. The inherent nature of this
8 problem is such that we must get the assistance of the
9 people themselves and other allied health groups in
10 order to dent it. Treatment in the past and in the
11 future will not dent this problem by virtue of its
12 public health aspects. In practically every man, woman
13 and child there is tooth decay or periodontal disease or
14 malocclusion. Fluoridation would assist greatly in a
15 way of a simplified analogy, we feel if the population
16 of Canada had the benefits of fluoridation through a
17 generation the total amount of work prevented would be
18 equivalent to what the total dental population of Canada
19 can do.

20 COMMISSIONER STRACHAN: Thank you
21 very much. Referring to your recommendation number 6,
22 do the members of the dental profession appreciate the
23 significance of dental research as it relates to
24 important services to the public and in prevention of
25 disease?

26 DR. NIKIFORUK: I think it is quite
27 simply erroneously concluded that because a man is
28 devoting full time to a service he is not aware of the
29 significant research. I think in our own area we have
30 very good evidence that the average man in dental
practice has a, not only an interest but had demonstrated
that in a very concrete manner.

In about 1920 when I was unable to



1
2
3
4 observe this scene I read that as a memorial to the
5 dentists who died during the First World War there was
6 a significant sum of money raised by the members of
7 the dental profession in order to start programs of
8 research. More recently a division of dental research
9 at the University of Toronto was formed and by the
10 campaign commenced amongst the profession in Ontario
11 and the alumni of the University of Toronto they
12 contributed in the neighbourhood of \$132,000.00 in
13 order to get concrete, definite dental research programs
14 started at the University of Toronto. This amount
15 was subsequently supplemented by the efforts and the
16 very, very vital efforts of the business community.
17 The business community, after observing that the dentists
18 did help themselves in this area of dental research,
19 assisted us in a very vital way.

20 In addition to that I might add that
21 the Canadian Dental Association was the first group to
22 commence a student aid program in order to assist
23 suitable candidates interested in pursuing an academic
24 career to continue with their graduate training. This
25 is consequently being supplemented by the National Research
26 Council.

27 There are at least these three areas
28 in which the members of the profession have demonstrated
29 a keen interest in the area of dental research.

30 COMMISSIONER STRACHAN: It may be
appropriate to observe that the first man to benefit
from that Canadian Dental Association program is soon
to be the president of the University of British Columbia.



CONFIDENTIAL

original. This seems to me that as a memorial to the
 dentist who died in the first world war there was
 a significant amount of money raised by the members of
 the dental profession in order to start programs of
 research. More recently a division of dental research
 at the University of Toronto was formed and by the
 campaign conducted amongst the profession in Ontario
 and the dental community the University of Toronto they
 contributed in the field of \$132,000.00 in
 order to get concrete, the dental research program
 started at the University of Toronto. This amount
 was substantially supplemented by the efforts and the
 very, very vital efforts of the business community,
 the business community, after observing that the dentist
 did help themselves in this area of dental research,
 assisted us in a very vital way.

In addition to that I might add that
 the Canadian Dental Association was the first group to
 commence a student aid program in order to assist
 students who were interested in pursuing an academic
 career in dentistry with their graduate training. This
 is consistently being supplemented by the dental profession
 and the dental community.

There are at least three areas
 in which the members of the profession have demonstrated
 a keen interest in the area of dental research.

QUESTIONS: (1) How many
 individuals to have that the first step to benefit
 from the Canadian Dental Association program is now
 to be the president of the University of Toronto.



Ellis

9919

1
2
3
4 You refer, Dean Ellis, to the program
5 in Scarborough where you hope to start the program of
6 training for dental assistants. Will those members of
7 those classes be brought into the dental schools for
8 some training?

9 DEAN ELLIS: This training program is
10 designed to cover part of their time through Grades 10,
11 11 and 12 in the high school. During grade 12, when
12 some clinical experience is required, it is highly
13 probable they will be brought to the dental school for
14 a period of time which has not yet been worked out. This
15 program does not get underway at grade 10 level until
16 1963.

17 COMMISSIONER STRACHAN: Now, if I
18 may ask a few generalized questions. Could the standard
19 of dental service be raised and, to use the Chairman's
20 expression this morning, if a comprehensive dental
21 program were established?

22 DEAN ELLIS: Mr. Chairman and members
23 of the Commission, my personal view is no when you are
24 talking in terms of standards of dental service. I
25 suppose we must relate this, perhaps, to what has happened
26 in another country in which there has been a fairly
27 comprehensive program of dental service. Again, I have
28 been in Great Britain on several occasions in the last
29 ten years and we have had many British dentists come
30 to our school for some post-graduate work and we have
taken the opportunity on every occasion to get their
viewpoint in relation to dental services. I would say
that because of the limits that are placed on the better



... ..
... ..
... ..

... ..
... ..
... ..
... ..

... ..
... ..
... ..
... ..

... ..
... ..
... ..

... ..
... ..
... ..

... ..
... ..
... ..

... ..
... ..
... ..



Ellis

9120

1
2
3
4 types of dental service which the Canadian people are
5 used to and can expect under our system, these are not
6 provided in this system, the other system that I am
7 referring to except by way of release or permission from
8 headquarters. Many of these men, the majority of them
9 will comment that it reaches the point where they do not
10 attempt to do the job of work that, as I say, the
11 Canadian people are used to. I am referring to bridge-
12 work and porcelain-work and this kind of service which
13 I think our people are fully using. In my estimation
14 I do not think you can compare one country with another
15 because of the many variables that come into the picture
16 but in my estimation no service, no comprehensive service
17 that covers all people and particularly with the
18 limitations of personnel which has been referred to,
19 can possibly make for an improvement in standards of
20 service which is, I think, what you asked.

21 COMMISSIONER STRACHAN: I could not
22 resist asking you the question because you are the
23 gentleman most concerned with training dental personnel
24 to render a high standard of service to the public.

25 One other question I would like to
26 refer you to and this is a compound question and in part
27 you have referred to it. First of all, I am going to
28 ask, is dental service for children easier and simpler
29 than that for adults? Following that, can the fact be
30 reconciled that New Zealand has females with two years
training running a dental service to children while
North America recognizes two of our most important
specialties requiring post-graduate study, namely,



types of dental service which the nation of the
used to and our expert under the system, there was not
provided in this system, the other system is that I am
referring to except in way of release or permission from
least someone, some of these men, the majority of them
will comment that it is better the more they do not
attempt to do the job of work that, as I say, the
Canadian people are used to. I am referring to bridge-
work and porcelain-work and this kind of service which
I think our people are really want. In my estimation
I do not think you can compare one country with another
because of the man, variables that come into the picture
but in my estimation as service as compared to
the service which is, I think, what you asked.
CLAUDETTE: I could not
understand you the question because you are the
personnel is concerned with training dental personnel
to meet a high standard of service to the public.
The other question, would like to
refer you to and this is a compound question and in your
to have referred to it. First of all, I am asking
you, is dental service for children easier and this ex-
actly that for children? Following that, can the service be
provided to the low income, has been as with the young
population living in central areas of children?
to the service sometimes two of our own population
the service, regarding post-graduate study, dental



Ellis

9121

1
2
3
4 paedio-donty and ortho-donty as preferable and even
5 essential for the proper care of children.

6 DEAN ELLIS: The answer is, part of
7 your question, I would say the only difference between
8 dentistry for children and dentistry for adults is a
9 matter of the age of the patient. I would say very
10 emphatically that dentistry for children, because of
11 the fact the dentist is dealing with a developing mouth,
12 a mouth in a transitional state, where they have first
13 and second teeth, some being shed and some coming into
14 place and a multitude of growth changes going on you
15 are dealing with a factor in a child that is much more
16 complex and requires much more care in the future
17 development of the mouth. Therefore, under no
18 circumstances can you consider dentistry for children
19 easier or requiring less training than dentistry for
20 the adults.

21 I would say only in one sense might
22 dentistry for children be easier than for the adult
23 and that is because child patients are usually easier
24 to work for than adults, much to the contrary of the
25 general feeling of the people. The child patient
26 problem is not the child but the parents.

27 COMMISSIONER STRACHAN: Would you like
28 to continue? How can you reconcile that?

29 DEAN ELLIS: The question of two-year
30 training program for specialists in the field of
children dentistry or paediodontrists, I would not like
to leave the impression that dentists given a two-year
program for practising dentistry with children, we think



...and only as a preliminary

...for the purpose of

...the answer is, that

...I would say the only difference between

...and the other is that

...of the one of the other, I would say

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that

...the other is that



Ellis

9122

1
2
3
4 we teach graduates to go out of our institution to
5 practise dentistry for children and for adults, in fact
6 all kinds of dentistry. There is no question that there
7 are areas in the field of dentistry for children that
8 requires specialty training such as are the areas of
9 surgery or the area of treatment of the gum conditions
and other areas.

10 COMMISSIONER STRACHAN: One last
11 question: You have not referred to it but are any
12 plans under consideration for the training of dental
technicians?

13 DEAN ELLIS: No, and as far as the
14 Faculty of Dentistry is concerned it is a vocational
15 type of training, it is the kind of training that should
16 be done in the vocational school. The university does
17 not consider this university education and, therefore,
18 we have no plans for training dental technicians.

19 COMMISSIONER STRACHAN: Thank you
20 Mr. Chairman.

21 COMMISSIONER FIRESTONE: Dean Ellis,
22 I believe you were present when I asked Dean Hamilton
23 a question based on the brief which the teaching
24 hospitals of the University of Toronto submitted to
25 this Commission dealing with dentistry. I wonder
26 whether I could have your advice on this point and I
quote again:

27 "The people in the lower income group
28 "in this area and I suspect throughout
29 "the country do not in many instances
30 "receive the minimum of dental care



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Ellis

9123

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

"necessary for the maintenance of
"general health".

Based on your experience would you
concur with this observation?

-

-

-



Page 100

"The history of the institution"

of the institution

of the institution

of the institution

10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100



/ss

Ellis

9924

DEAN ELLIS: Yes, I would.

COMMISSIONER McCUTCHEON: You go one step further and say that no matter what the income bracket the people in Canada are in, the majority generally obtain the basic minimum dental treatment necessary for dental health.

DEAN ELLIS: I wouldn't say the majority, but a very sizeable percentage.

COMMISSIONER FIRESTONE: There would be a difference of degree between people in lower income groups suffering more than people that can afford to obtain the service and pay for it.

DEAN ELLIS : I would agree most heartily with that comment, and we have made reference to it in our own brief, only we went further and tried to establish through the Ministry of Welfare in the Province of Ontario what percentage or how many people might be in the category of whose income is such that they can afford only food, shelter and clothing for their families, and it is extremely difficult for them to provide health care, health service.

They receive some of this health care through hospitals, as far as the medicine is concerned. They receive virtually nothing except an emergency extraction treatment as far as dental care is concerned.

The numbers that we are told, and I wouldn't want to say that this is a final figure, but the number that appear to be in this area, in this group or category might be in the hundred and fifty to two hundred thousand range.

2001



Ellis 9925

COMMISSIONER FIRESTONE: Thank you very much Dean Ellis. Coming back to another point which was put to you in the form of a question by one of my fellow Commissioners, if I understood you correctly, you said that the introduction of the comprehensive dental care plan opening in Canada would not contribute to an improvement in the standards of dental care, and I take it that reply related to the quality of dental care.

Would you also say that under such a plan the present standards which you described as fairly high, would be available to many more people, and as a result, the average Canadian would be better off as far as his taking care of dental requirements are concerned?

DEAN ELLIS: I would answer that by saying that if the standards of these people can be maintained at our present level of standards in Canadian dentistry, certainly we should do everything in our power to provide these services for these marginal income people, and people in this category, but in order to do this, the cost would be astronomical and I think inevitably, because of costs that are involved there might be a trend towards reducing the standards for all people.

I don't think there would be any question of it. It couldn't be done apart from even the available personnel.

COMMISSIONER FIRESTONE: It could not be done because of the inadequacy of personnel. That was one factor. What are some other factors?

DEAN ELLIS: I feel the factor of cost is perhaps even greater.



Ellis 9926

COMMISSIONER FIRESTONE: Didn't you suggest, sir, that the output of the available number of dentists could be doubled, productivity of the dentists, if there were a proper coordinated scheme of using dental assistants, and I would presume if the output of the dental profession, plus assistants could be doubled, and if you are paying less to these dental assistants than you are paying to the dentists, the cost per unit of service might go down a little?

THE CHAIRMAN: Dean Ellis did not relate that to any plan. He was talking about the present situation with or without a plan.

DEAN ELLIS: I don't know whether in your question there is implied, or the idea that these dental assistants do any work in the mouth. They do not. The dental hygienist does a limited -- it's a very important preventive health service, as Dr. Nikiforuk is talking about, where prevention and education are so tremendously vital to reducing the incidence and the backlog of the need of the people. This I would certainly go along with.

COMMISSIONER FIRESTONE: I am basing my question, sir, on your own earlier observation that the productivity of the dentists, with the help of these various assistants, including dental hygienists could be doubled; and if you double the output and you do not pay twice as much for the services, because presumably the dental assistants are getting paid less than a hygienist and dentist and you spread the total cost over the number of services that are being provided, these services may



Ellis 9927

not rise the same proportion as if you had twice as many dentists.

That is what I am saying, so I am just trying to learn from you why those costs have to be astronomical if what you are suggesting is a practical proposal.

DEAN ELLIS: Well, the suggestion is based on the idea of comprehensive dental service for all people. Now, it is our belief that at the present time somewhere between 25, 30, 35% of the people are getting what we might call an adequate dental service.

If you had the other 65%, immediately you are trebling the actual need for service --- only doubling the need, or at least the productivity to produce this.

We are in areas of economics, quite frankly, I am out of my depth in and certainly I do not feel I can give you an answer. I do not believe that, at the present time, Canada can support a comprehensive dental service for all people and maintain the standards that the Canadian people have learned to accept and demand, because there are many factors which only an economist, I am quite sure, can project.

Certainly, it is away beyond me.

COMMISSIONER FIRESTONE: I take it from what you are saying that if such were the objective it may take a number of years to develop the resources to do it. Maybe five, ten years?

DEAN ELLIS: I would go further and say probably twenty-five years.

not rise the same problem as if you had twice as many

That is what I am saying, so I am just

trying to learn from you what those costs have to be
assumed that it was you and suggesting is a possibility

But I think: well, the suggestion is

based on the idea of comprehensive dental service for all
people. Now, it is not clear that at the present time
somewhere between 25, 30, 35 of the people are getting
what we might call an adequate dental service.

If you had the other 65, immediately
you are doubling the dental need for service -- only

doubling the need, or at least the productivity to produce
this.

As one in a series of economics, quite
frankly, I am one of my kind in and certainly I do not
feel I can give you an answer. I do not believe that,

at the present time, Canada can support a comprehensive
dental service for all people and maintain the standard.

That the Canadian people have learned to accept and
tolerate, because there are many factors which only an
economist, I suppose, can protect.

Certainly, it is very hard to

to make one thing clear: I think it is

that you are saying that if such were the objective it
may take a number of years to develop the resources to do

it. I think that, yes, yes.

That is right. I would like to mention and

very much to mention that.



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Ellis 9928

COMMISSIONER FIRESTONE: Thank you very much, sir.

THE CHAIRMAN: Thank you very much, Dean Ellis, and we are very grateful to you for this information.

THE SECRETARY: We will now have the Faculty of Pharmacy, Dean Hughes who proposes to read his summary and conclusions of this brief which will be Exhibit 273. Go on with the questioning with regard to the brief and then after the completion of this, read his statement which will be known as 273A.



---EXHIBIT NO. 273: Submission by the Faculty
of Pharmacy.

SUBMISSION OF
THE FACULTY OF PHARMACY, UNIVERSITY OF TORONTO

APPEARANCES:

DEAN F.N. HUGHES,
PROF. I.E. STAUFFER,
PROF. H.J. FULLER,
PROF. WALKER

DEAN HUGHES: Mr. Chairman, may I
present my colleagues, Prof. Stauffer, Assistant Professor
in Hospital Pharmacy Administrator. On my right is Prof.
Walker and Prof. Fuller.

Mr. Chairman, Members of the Commission.
This submission is respectfully presented by the Faculty of Pharmacy, University of Toronto,
the only school of pharmacy in the Province of Ontario.
Although the Faculty is interested in all of the proceedings of the Commission it is especially concerned with
those terms of reference which are related to pharmaceutical education, at all levels, and to pharmaceutical
research, with particular reference to the Province of Ontario.

The responsibility of this Faculty as reflected in the undergraduate and graduate curricula is
(a) to provide an adequate scientific, humane and professional education to enable its graduates to render the

such as the Faculty of Pharmacy, of the University of Toronto.

--- 1967, Dec. 1977

Dr. [Name]

Dr. [Name], M.D., F.R.C.P.
[Address]

Dear Sirs: Mr. Chairman, my name is [Name]

represent my colleagues, Prof. [Name], Assistant Professor in Hospital Pharmacy Administration. On my right is Prof. [Name] and Prof. [Name].

Mr. [Name], Member of the Commission. This submission is respectfully presented to you.

by the Faculty of Pharmacy, University of Toronto, the only school of pharmacy in the Province of Ontario. Although the Faculty is interested in all of the progress of the Commission it is especially concerned with those areas of reference which are related to pharmacy education, at all levels, and to pharmaceutical research, with particular reference to the Province of Ontario.

The responsibility of this Faculty is reflected in the undergraduate and graduate curriculum to provide an adequate scientific, human and professional education to enable the graduates to render a



Hughes 9930

highest quality of pharmaceutical service in all of the branches of pharmaceutical practice in the Province, and (b) to maintain a strong research program not only to extend the frontiers of knowledge with respect to drugs but also thereby to provide the opportunity for good graduate students to develop into competent pharmaceutical scientists. (Paragraphs 5 to 9 and Appendices A and B).

Recent undergraduate enrolments have shown three trends when compared with pre-war registrations: (i) a fourfold increase in percentage of women students, (ii) a doubling of the percentage of students from the Toronto area, and (iii) a reduction in pharmacy enrolment in relation to total University of Toronto enrolment. (Paragraphs 10 to 13 and Appendix C).

I think, Mr. Chairman, I might add in connection with this paragraph that in the body of the brief, in Paragraph 11, we refer to two pre-pharmacy courses in other institutions in Ontario. Assumption University and Lakehead College. There has just recently now been established a third of these at Ottawa University to commence next September.

Direct financial aid to pharmacy students has almost doubled over the past five years. The largest single source has been Dominion-Provincial Student-Aid Bursaries. Alumni and local pharmaceutical associations have provided generous support. As enrolment increases additional funds will be required but the need of undergraduate pharmacy students should, in our view, be proportionately no greater than that of students in other divisions of the University. (Paragraph 14).



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

Figure 1

...in all of the ...
...of ...
...and (a) ...
...extensive ...
...the opportunity for ...
...to develop into competent ...
...to 8 and ...
...about ...
...compared with ...
...in percentage of ...
...of the percentage of ...
...and (ii) ...
...of Toronto ...
...and ...
...I think, ...
...with this ...
...we refer to two ...
...Assessment ...
...and ...
...at ...
...
...to ...
...has ...
...has been ...
...and local ...
...As ...
...will be ...
...in our view,
...of ...
...of the ...



Hughes 9931

Perhaps one reason for this is our students are able to obtain employment in the Summer without any great difficulty.

During the past few years the number of graduates has been inadequate to meet demands particularly in hospital pharmacy, the pharmaceutical industry, government laboratories, teaching and research, and in retail pharmacy outside the Toronto area. (Paragraphs 15 to 18).

The maximum undergraduate capacity of this Faculty of Pharmacy will barely meet only the immediate future requirements of the Province. A new Faculty of Pharmacy will therefore be required in Ontario by 1965. It is recommended that the Commission affirm in its findings the early need for a second faculty of pharmacy in the Province of Ontario in association with a university situated in a part of the Province other than the Toronto area. (Paragraphs 15 and 19).

Conditions in pharmacy which we designate hospital pharmacy are not such as to make this field sufficiently attractive to hold a sufficient number of pharmacists who are qualified in this specialty. To correct these conditions will require legislative action, improvement in facilities and in salary schedules. (Paragraph 17).

A graduate study program leading to the degree, Master of Science in Pharmacy, was commenced in 1953 to meet in part the demand for graduates for research positions in industry, in government laboratories and teaching posts. Twenty-two candidates have been admitted to the degree, but many more are required. The new



perhaps one reason for this is that

students are able to obtain employment in the summer without any great difficulty.

During the past few years the number

of graduates has been inadequate to meet demands particularly in hospital pharmacy, the pharmaceutical industry, government laboratories, teaching and research, and in retail

pharmacy outside the Toronto area. (Paragraphs 15 to 18).

The maximum undergraduate capacity of

this Faculty of Pharmacy will barely meet only the

immediate future requirements of the Province. A new

Faculty of Pharmacy will therefore be required in Ontario

by 1955. It is recommended that the Commission affirm

in its findings the early need for a second faculty of

pharmacy in the Province of Ontario in association with a

university situated in a part of the Province other than

the Toronto area. (Paragraphs 15 and 19).

Conditions in pharmacy which we

designate hospital pharmacy are not such as to make this

field sufficiently attractive to hold a sufficient number

of pharmacists who are qualified in this specialty. To

correct these conditions will require legislative action,

improvement in facilities and in salary schedules. Trans-

A graduate study program leading to the

degree, Master of Science in Pharmacy, was commenced in

1953 to meet in part the demand for graduates for research

positions in industry, in government laboratories and

teaching posts. Twenty-two candidates have been admitted

to the degree, but many more are required. The new



Hughes 9932

building for the Faculty, to be ready in 1963, will have accommodation for up to 30 graduate students. (Paragraphs 20, 27).

To improve the quality of pharmaceutical service in hospitals three stages of post-graduate training are proposed, all involving close cooperation between the University and teaching hospitals for pharmacy internes. The development of this program will require the enlargement of pharmacy facilities in at least four or five hospitals in the Toronto area and some regular financial support of the teaching program. It is recommended for this purpose:

(a) that capital funds be provided to teaching hospitals in Metropolitan Toronto on application for enlargement of the Pharmacy Departments in order to meet the requirements of the Canadian Society of Hospital Pharmacists for Internships in Hospital Pharmacy; and these are in the appendix,

(b) that annual federal-provincial health grants be provided to the Faculty of Pharmacy, University of Toronto, on the basis of \$500 for each post-graduate hospital pharmacy student enrolled and to each teaching hospital on the basis of \$1,000 for each pharmacy interne enrolled. (Paragraphs 21, 22).



Hughes

9933

These amounts, Mr. Chairman, are modest and conservative, having regard to the cost involved by both institutions in providing this education.

(x) There is a need for a well-organized, regular program of "continuing", i.e., post-graduate education for pharmaceutical practitioners. The university should assume responsibility for the direction and the presentation of such courses, but financial support will be required. It is recommended that there be provided for the Faculty of Pharmacy, University of Toronto, by a federal-provincial health grant or through some other appropriate government agency the sum of \$10,000 annually for the support of the proposed program of post-graduate education for pharmaceutical practitioners.

(xi) Good progress has been made since active research was commenced in the Faculty ten years ago. Outside financial support has come mainly from government sources. The normal and essential development of this program will require at least an additional \$60,000 annually from sources outside the university if the need for pharmacy graduates with higher degrees is to be met for industry, government laboratories, teaching and research. It is the view of the Faculty that the pharmaceutical industry in Canada, which will be one of the major beneficiaries, has an obligation to support research in the schools of pharmacy. It is suggested, therefore, that a reasonable share of the additional support required ought to be supplied by the industry. This will still leave a substantial portion to be provided principally by government agencies such as



Hughes

9934

National Research Council and Medical Research Council.

(xii) The new Pharmacy Building to be completed in 1963 should provide space and facilities for a sufficient number of undergraduates for the immediate future only. It should, however, meet requirements for graduate study and research for at least up to ten years. Assuming a surplus of qualified applicants for admission to the undergraduate course and in order to provide fair geographical distribution of practising pharmacists in Ontario, it will probably be necessary to accept a higher percentage of applicants from the Province outside the Toronto area until a second school of pharmacy has been established. In other words, a higher percentage of Toronto applicants will probably be refused admission unless a change should occur in the geographical distribution of applicants.

Mr. Chairman, we might leave the statement, if you like, until after the questions.

THE CHAIRMAN: Yes, thank you, Dean Hughes and I may say that we are grateful to you and to those who prepared the brief, for the factual information and the tables which the brief contains.

Now, you are graduating a certain number each year, and that figure is what? I know it is here, but what is your number?

DEAN HUGHES: It has been running around 75, 80 to 90 capacity.

THE CHAIRMAN: Per year?

DEAN HUGHES: Yes.

THE CHAIRMAN: But you say that, in



Hughes

9935

paragraph 6 of the recommendations, is barely sufficient to meet the needs of the immediate future?

DEAN HUGHES: The capacity in our new building will be 125, and that will be barely sufficient to meet the needs.

THE CHAIRMAN: How many, are you in a position to say, how many of these in a sense are deflected from the practice of their profession into becoming detailmen and so forth with the pharmaceutical supply companies?

DEAN HUGHES: I would say, sir, at the present time a rather too small percentage are going into pharmaceutical industry.

THE CHAIRMAN: I am not talking about the industry. I am talking about the salesmen, and the detailmen.

DEAN HUGHES: Yes, introducing the new medication to physicians.

THE CHAIRMAN: Yes, they call it the education of physicians.

DEAN HUGHES: There are a very small percentage of our present graduating classes taking on this work at the present time.

THE CHAIRMAN: Well, it is not a serious proposition of the School of Pharmacy, the fact that the facilities of the school are being used for a purpose for which it was not really intended. I take it the school exists to train, educate pharmacists for the practice of their profession in Canada?

LEAN HUGHES: Primarily, under The



Hughes

9936

Pharmacy Act.

COMMISSIONER FIRESTONE: Dean Hughes, you say in paragraph 5 on page 2 that the number of graduates has been inadequate to meet demands, particularly of the hospital pharmacies, the pharmaceutical industry, government laboratories, teaching and research, and pharmacies outside the Toronto area. Would one of the reasons be that pharmacists do not spend perhaps as much of their time in the pursuit of the pharmaceutical profession once they enter retail pharmacies, and they may be doing a lot of other things besides pharmaceutical work? Would that be one factor?

DEAN HUGHES: That, of course, sir, would really have no bearing on the shortage in hospital pharmacies, for example, or the industry, or the laboratories.

COMMISSIONER FIRESTONE: Can we just think about it? If you have a given goal and you need more pharmacists to go into retail pharmacies to sell candy and cameras and cosmetics, there won't be enough pharmacists left to go into the hospitals and industry and the laboratories, and if a good many pharmacists do this, there will be fewer left to do this specific job and my question to you is: have you or your colleagues any suggestions or recommendations with respect to increased utilization of the pharmacist's time devoted to pharmacy?

DEAN HUGHES: In other words, if there could be a re-distribution of the qualified personnel in all divisions, would there still be a shortage?



100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100



Hughes

9937

COMMISSIONER FIRESTONE: Well, the pharmacists, as you know, devote some time to pharmaceutical work and some time to non-pharmaceutical work. Is there anything that you, on the basis of your experience, could suggest to increase the utilization of the pharmacist in terms of pharmaceutical work and reduce, perhaps, somewhat, the work he is doing in the field other than pharmacy?

DEAN HUGHES: That is in retail pharmacy particularly?

COMMISSIONER FIRESTONE: Yes, and perhaps the area the Chairman mentioned; if the pharmacist is used as a salesman, then perhaps he is not performing a completely pharmaceutical function?

DEAN HUGHES: Yes, the present shortage is already from our observation creating a trend which we believe is gradually improving that situation. As we have pointed out in the brief, the ratio of retail pharmacies to population in Ontario has altered considerably in the past 10 years, due to this shortage. It was one in 2,300, I believe, in 1951. As a matter of fact, if we went back further, to 1941, it was about one to 2,100. Today it is around one to 3,200 and as we predicted, if this trend continues without a great increase in the number of pharmacists being available, by 1971 it will be one to 4,000, which will, in itself, create a greater effort on the part of the pharmacist to concentrate his attention on the professional aspect, because he will not then have the need to have the auxiliary source of income to maintain his establishment.



Hughes

9938

COMMISSIONER FIRESTONE: I admit this is a very difficult question to answer, and if you wish to give it a little further thought, and have some other suggestions to make after consultation with your colleagues, or anyone else on your Faculty, and you wish to communicate these to us, we would be happy to have them, and please feel free to communicate with us. We are really looking for an answer to what is quite a serious problem, as you have outlined to us.

COMMISSIONER VAN WART: Does not the pharmacist have clerks in his store who deal out these other products we are speaking about?

DEAN HUGHES: Yes, Dr. Van Wart, that is true, quite true, and I think today that is to a greater extent true than it was 20 years ago. I think though that what Dr. Firestone means is that nevertheless the pharmacist who is responsible for the overall operation still must give some of his time to that aspect.

COMMISSIONER FIRESTONE: That is correct, sir.

PROF. FULLER: In Canada, I don't know the figures for Ontario alone, there are at least 675 communities so small that they can barely support one pharmacy, and in those pharmacies only about 28% of their total receipts are obtained from the dispensing of prescriptions. They must sell candy bars and other things to live in those communities. In larger centres like Toronto, Hamilton, London and Ottawa, I think an investigation would show that in many pharmacies where there are more than two pharmacists employed, the



COMMISSIONER VAN WART: I admit this

is a very difficult question to answer, and if you wish to give it a little further thought, and have some other suggestions to make after consultation with your colleagues, or anyone else on your Faculty, and you wish to communicate these to us, we would be happy to have them, and please feel free to communicate with us. We are really looking for an answer to what is quite a serious problem, as you have outlined to us.

COMMISSIONER VAN WART: Does not the

business of having these in his store who deal out these

mean anything we are speaking about?

MR. HUGHES: Yes, Dr. Van Wart, that

is true, quite true, and I think today that is to a greater extent true than it was 20 years ago. I think though that what Dr. Hughes means is that nevertheless the pharmacist who is responsible for the overall operation still must give some of his time to that aspect.

COMMISSIONER TRESTON: That is

correct, and

MR. TRESTON: In Canada, I don't know

the situation for Ontario alone, there are at least 250 communities so small that they can barely support one pharmacy, and in those pharmacies only about 5% of their total receipts are obtained from the dispensing of prescriptions. They must sell candy bars and other things to have in those communities. In larger centres like Toronto, Montreal and Ottawa, I think an investigation would show that in many pharmacies where there are more than two pharmacists employed, the



Fuller

9939

pharmacists spend the majority of their time in professional work, and the non-professional activities are performed by non-professional personnel.

COMMISSIONER McCUTCHEON: If he didn't sell candy bars in these small communities, why, the community wouldn't have a pharmacist?

PROF. FULLER: That is right.

COMMISSIONER FIRESTONE: I take it that the majority where this use is is in the larger urban centres and it is with the intention of making greater use of the pharmacists professionally in those urban centres that we are concerned, and would you please communicate any suggestions or recommendations you may arrive at to our Secretary?

DEAN HUGHES: I shall be pleased to do that.

COMMISSIONER FIRESTONE: Thank you.
In paragraph (xi), on page 3 of your summary, you say:

"Good progress has been made since active research was commenced in the Faculty ten years ago."

Sir, what happens if one of your research workers comes up with a new type of drug that has significant commercial application?

DEAN HUGHES: Sir, he would be in the same position as any other research worker in the university. In other words, we have no research funds that are tied in any respect in the matter of patent rights and the patent regulations under which such research is operated in the university are very clearly



Hughes

9940

defined.

COMMISSIONER FIRESTONE: In other words, if he gets, for example, a research grant from government sources, that is, taxpayer sources, and he develops a new drug with commercial applications, he can patent it and sell his patent or make whatever other disposition he wishes to, even though he had developed that drug as a result of research which was financed through public funds? Is that the present situation?

DEAN HUGHES: No, sir.

COMMISSIONER FIRESTONE: Well, could you explain it please?

DEAN HUGHES: I suspect that a member of the Commission, who is also a member of the Board of Governors, will know the details better than I, but the matter of patenting would be done by the university.

COMMISSIONER FIRESTONE: And the benefits then will be accruing to the university, or to the individual?

DEAN HUGHES: Primarily to the university and the department concerned.

COMMISSIONER BALTZAN: What special preparation or training is required of a hospital pharmacist? You seem to have a lot of difficulty in obtaining people to supply hospital requirements.

DEAN HUGHES: In our four-year curriculum we offer a small amount of specialization in the fourth year, at which time hospital pharmacists may take three



Hughes

9941

subjects which are of particular relevance to their work. However, with the increasing need for a proper type of pharmaceutical service in the hospitals, we have embarked upon a post-graduate internship program, which will better train graduates of pharmacy for that particular specialty.

COMMISSIONER BALTZAN: There are definite requirements of a hospital pharmacist as against the man who dispenses drugs in the drugstore?

DEAN HUGHES: There are no legal requirements.

COMMISSIONER BALTZAN: Not legal, I mean hospital requirements.

DEAN HUGHES: No, there are really no requirements operating at the moment, except the supply and demand of competent persons. There is no requirement which hospitals have.

COMMISSIONER BALTZAN: I am not speaking in the legal sense. I am just trying to get things straightened out about any special training so as to make that service better in the hospital. You say you have at least three subjects and you have entered upon a post-graduate program, so there is a distinction?

DEAN HUGHES: Yes, we are starting a program which we hope will train them.

THE CHAIRMAN: Did I understand you correctly, and I may not have, Dean Hughes, that a hospital may employ anyone without special pharmaceutical training to operate a hospital pharmacy?

DEAN HUGHES: Under the law that is true,



Hughes

9942

1
2
3 sir.

4 THE CHAIRMAN: The hospital, of course,
5 takes the responsibility?

6 DEAN HUGHES: Yes, and for that reason
7 we have suggested legislative action may be required.

8 THE CHAIRMAN: And do you go along
9 with the proposition that hospitals with over 50 beds
10 should have a full-time pharmacist?

11 DEAN HUGHES: Yes, adequate service
12 either for 50 beds or 75 beds or whatever you might say.

13 THE CHAIRMAN: Then you had the state-
14 ment, Dean Hughes, which you wished to read?

15 DEAN HUGHES: Yes, Mr. Chairman. In
16 connection with this statement, Mr. Chairman, we make
17 reference to the Hinchcliffe Report. I presume that will
18 be known to the members of the Commission. It is a
19 report of a Committee on the cost of prescribing in
20 Great Britain.

21 THE CHAIRMAN: In England and Wales.

22 DEAN HUGHES: That is true, sir.
23
24
25
26
27
28
29
30



Although the Faculty of Pharmacy is, of course, concerned particularly with pharmaceutical education and research, we do have certain opinions regarding the provision of pharmaceutical services under a comprehensive medical care plan. Some of these may be summarized as follows:

(i) In our view all prescribed drugs should be included in the plan at one time and preferably at its commencement. The inclusion of some prescribed drugs only or the adoption of a formulary which implies restrictions on prescribing accordingly would mean that the plan would not be "comprehensive". Physicians and dentists would feel under some pressure to prescribe drugs which were included in preference to others for which the patient would pay. If expensive medication only were included in the drug bill would thus be unnecessarily increased. If expensive medication were excluded the most effective drugs at times would not always be ordered. In our view the best possible health plan for all Canadians would require the inclusion of all prescribed medicines and certain therapeutic devices. They would be defined by appropriate bodies prefer over at the commencement of the plan. One further point in that connection, I would refer to the Hinchdliffe Report in that connection, where they considered after studying the whole question of limitation of drugs available under the plan -- this was part of their conclusion: To be of practical value any scheme that limited the range of drugs which may be prescribed and supplied under the national health services must satisfy

Although the Faculty of Pharmacy is,

of course, concerned primarily with pharmaceutical

education and research, it does have certain relations

regarding the activities of the pharmaceutical industry

a corporate medical department. Some of these may

be summarized as follows:

(i) In the view of the pharmaceutical industry

the inclusion of the drug at the time and preferably at

the commencement. The inclusion of some prescribed drugs

only on the condition of a formula which includes

testament as on prescribing accordingly would mean that

the drug would not be "compensated". Physicians and

patients would feel that some pressure to prescribe

drugs which were included in preference to others for

which the patient would pay. It extensive restriction

only are included in the drug bill would not be

inadequate relative to the extent of the restriction which

excluded the most effective drugs at times would not

be adequate to order. In the view of the patient the health

plan and the physician would receive the benefit of

all the medical knowledge and certain therapeutic services.

would be a more appropriate method of action over

at the commencement of the plan. The first point in

that consideration, I would refer to the inclusion of

restriction in the formula, where they are considered after

the inclusion of the restriction of limitation of drugs

the inclusion of the drug in the plan was done in their

concern. It is of course true that the plan is not

limited to the drug. It would also be possible to

restrict the inclusion of the drug in the plan and thereby



1
2
3 the following conditions. It should involve no loss
4 of efficacy of treatment of patients. Two, no
5 administrative complexities should be involved, for
6 example, doctors and pharmacists should not be expected
7 to cope with an unreasonable burden of extra paper-work
8 and three, substantial savings should occur to the
9 exchequer. The report went on to compare the Australian,
10 Danish and New Zealand plans which had limited drugs
11 in some way. They pointed out in each instance the
12 plan in a given country was either administratively too
13 complex, or in the case of Australia lists of permitted
14 drugs appeared to be so limited as to provide an
15 incomplete pharmacopeia for the full range of clinical
16 treatment.

16 THE CHAIRMAN: On that basis, Dean
17 Hughes, Dr. Ferguson of the Connaught Laboratories
18 expressed a contrary view here on Friday. Are you
19 familiar with that?

20 DEAN HUGHES: Yes.

21 THE CHAIRMAN: Have you ever tried to
22 resolve that difference of opinion with Dr. Ferguson?

23 DEAN HUGHES: I have discussed it with
24 Dr. Ferguson whom I know very well.

25 THE CHAIRMAN: His view was that the
26 expensive and most badly needed drugs

27 COMMISSIONER McCUTCHEON: Over a long
28 period of time.

29 THE CHAIRMAN: By those who require
30 them over a long period, as distinct from one prescription
or a short period, those are the drugs which should be



the following conditions. It should involve no loss

of either of treatment of patients. No.

Administrative charges should be included, but

expenses, doctors and consultants should not be expected

to incur with an unreasonable burden of extra pay

and fees, except in cases where they occur in the

examined. The report should be to compare the Australian

system with the system of the United States

in some ways. They should not in any way involve the

plan of a given country and other administrative too

much, or in the case of Australia a list of some that

might be used to be included as to provide an

immediate plan for the 12 cases of clinical

reference

On that basis, I am

convinced, for the reason of the (un)profitable

to be used to test the view on Friday. Are you

in line with this?

Very much, yes.

That is, I have not even tried to

have you had literature or opinion with Mr. Thompson?

Good. I have discussed it with

Mr. Thompson when I was very ill.

His view was that the

... of the best plan for the future ...

... of the

... of the

... of the

... of the



Hughes

9945

furnished free, included in a plan?

DEAN HUGHES: I have to say, sir, I am satisfied that this plan would be gradually extended, recommended it would be gradually extended as it became feasible.

THE CHAIRMAN: I think he said that is what has happened in Australia, they started with a number and added 60 or 70 and he didn't think much of that.

DEAN HUGHES: I still suggest that there is the danger where expensive drugs are free under certain conditions, and others are not.

THE CHAIRMAN: That is expensive to those requiring them over a long period?

DEAN HUGHES: Yes, I also deal with the other aspects of it in a section of this submission.

(ii) No restriction should be placed on the physician or dentist with respect to prescribed medication except as to limitation of quantities prescribed and frequency of refilling. For example, we believe that the principle of requiring practitioners to prescribe medication only by chemical or generic name to be entirely wrong. This presupposes that any given dosage form containing the same quantities of a drug will have the same clinical effect. It has been clearly shown that this does not necessarily follow.

We included three references, Mr. Chairman. I have copies of the first I could submit if the Commission would like it, the first paper of Levy and Nelson. I might read the first section which gives



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

turned back, included in a plan.

DEAN HUGHES: I have to say, sir, I

am satisfied that this plan would be gradually extended, recommended it would be gradually extended as it became

THE CHAIRMAN: I think he said that

is what has happened in Australia, they started with a number and added 60 or 70 and he didn't think much of that.

there is the danger where expensive drugs are free under certain conditions, and others are not.

THE CHAIRMAN: That is expensive to

those requiring them over a long period?

DEAN HUGHES: Yes, I also deal with

the other aspects of it in a section of this submission.

(ii) No restriction should be placed on the

availability of drugs with respect to prescribed medication

except as to limitation of quantities prescribed and

frequency of refilling. For example, we believe that the

principle of requiring practitioners to prescribe

medication only by chemical or generic name to be entirely

wrong. This presupposes that any given dosage form

containing the same quantities of a drug will have the

same clinical effect. It has been clearly shown that this

does not necessarily follow.

He included three references, Mr.

Chairman. I have copies of the first I could submit if

the Commission would like it, the first paper of Levy

and Nelson. I might read the first section which gives



Hughes

9946

1
2
3
4 the key to what is in it: There is a mistaken belief
5 among many that the active constituent as a chemical
6 entity is the sold basis for the pharmacological
7 effectiveness of a pharmaceutical product. It is the
8 purpose of this review to show that the physiological
9 response to the administration of a given drug product
10 is frequently a function of both the pharmaceutical
11 formulation of the particular dosage form as well of
12 the active ingredient.

13 THE CHAIRMAN: We will be pleased to
14 have this.

15 THE SECRETARY: 273B, sir.

16 ---EXHIBIT NO. 273B: Pharmaceutical Formulation
17 and Therapeutic Efficacy.

18 DEAN HUGHES: In that cortex too,
19 Mr. Chairman, at the hearing of the Select Committee on
20 Drugs Dr. Ward Smith, who is director of the Attorney-
21 General's laboratory opened his presentation by indicating
22 that his laboratory could detect certain things about
23 a drug, but they couldn't test others, for example,
24 he said his analytical test didn't test the action of
25 the drug, that is, the purpose for which it is being
26 used nor does it test, for example, any peculiarities
27 of this particular kind of medication.

28 The prescriber should thus be free
29 to order any specific brand of a drug which, from his
30 experience, he believe is likely to have the desired
effect. For the same reason we believe it to be wrong



2000

Number

The key to what is in the above is a mistaken belief
some may have that the active constituent is a chemical
entity is the substance for the pharmacological
effectiveness of a pharmacological product. It is the
purpose of this review to show that the physiological
response to the administration of a given drug product
is frequently a function of both the pharmacological
formulation of the particular dosage form as well as
the active ingredient.

THE REVIEWER: It will be pleased to

have this.

THE REVIEWER: 2000, etc.

and Therapeutic Effects of

THE REVIEWER: In that context too,

Mr. Chairman, at the hearing of the Select Committee on
Drugs, Mr. and Mrs. Smith, who is director of the Veterans
General Laboratory stated his presentation is indicating
that his laboratory could detect certain things about
a drug, but they couldn't test others, for example,
he said that a particular test didn't test the action of
the drug, that is, the response for which it is being
used nor does it test, for example, any peculiarities
of this particular kind of reaction.

The presenter should thus be free
to order any specific kind of a drug which, from his
experience, he believes is likely to have the desired
effect. For the same reason we believe it to be wrong



Hughes

9947

1
2
3
4 to give the pharmacist the legal right to substitute
5 another brand for one prescribed without express
6 permission of the prescriber. This likewise, Mr.
7 Chairman, was considered by the Hinchcliffe Report,
8 and they had this to say in a couple of sentences:

9 It is unfair in our opinion to impose on the pharmacist
10 the onus of substituting the equivalent preparation for
11 the one prescribed. The term equivalent may be used in
12 two distinct senses. It may imply identical equivalent
13 if the identical is susceptible to proof by chemical
14 methods, but even with products containing identical
15 therapeutic substances there may be pharmaceutical
16 variations. The term equivalent may also imply the
17 therapeutic equivalent which can only properly be tested
18 by the prescriber. Then they continue to discuss the
19 effect this would have on the prescriber, and they
20 finally concluded in these few words: For these reasons
21 we reject substitution as a practical method of securing
22 economies in the drug bill. The only effective long
23 term answer in our view is to train doctors to prescribe
24 critically and with discrimination.

25 THE CHAIRMAN: I take it then you
26 don't favour the extension of the recent legislation
27 in Alberta?

28 DEAN HUGHES: No sir, we don't feel
29 it is sound. As we say here in the last sentence of
30 this, we believe the best combination of economy and
therapeutic efficacy can be achieved by close
collaboration between physicians and pharmacists at
the local level.



to give the pharmacist the legal right to substitute
 another brand for one, provided without express
 permission of the prescriber. This likewise, Mr.
 Chairman, was contained by the Hincheliff Report,
 and they had this to say in a number of sentences:
 'It is unfair in our opinion to impose on the pharmacist
 the duty of substituting the equivalent preparation for
 the one prescribed. The term equivalent may be used in
 two distinct senses. It may imply identical equivalent
 if the identical is essential to proof by chemical
 methods, but even with products containing identical
 therapeutic substances there may be pharmaceutical
 variations. The term equivalent may also imply the
 therapeutic equivalent which can only properly be tested
 by the prescriber. If they continue to discuss the
 effect this would have on the pharmacist, and they
 finally concluded in these few words: 'For these reasons
 we reject substitution as a practical method of securing
 economies in the drug bill. The only effective form
 term appears in our law as to that, doctors to prescribe
 their drugs and with discretion.'

THE CHAIRMAN: I take it then you
 don't favour the extension of the recent legislation
 in this regard?

DEAN BROWN: No sir, we don't feel
 it is sound. As we say here in the last sentence of
 this, we believe the best combination of economy and
 therapeutic efficacy can be achieved only by
 collaboration between physician and pharmacist at
 the local level.



Hughes

9948

1
2
3 THE CHAIRMAN: Has there been any
4 experience under the Alberta legislation?

5 DEAN HUGHES: I have heard of none,
6 sir. Is it operating?

7 THE CHAIRMAN: I don't know. I was
8 wondering if the fact that it was in effect had brought
9 forward any experiences?

10 DEAN HUGHES: We certainly heard of
11 none down here. The third point --

12 (iii) Pharmaceutical benefits should be
13 available only through hospital pharmacies (for hospital
14 patients) and through retail pharmacies (for patients
15 outside hospitals). Proposals are sometimes made that
16 medicines should be purchased centrally and distributed
17 by a government agency, or alternatively that distri-
18 bution to patients be through dispensaries established
19 in clinics or in "health centres". All aspects of the
20 provision of pharmaceutical benefits were considered in
21 the Hinchcliffe Report. In connection with government
22 purchase and distribution the Committee reported, in
23 part: "the high cost of setting up such a service as
24 well as the administrative expenses often associated with
25 central organizations would almost certainly increase the
26 cost of medicines rather than reduce it." In regard to
27 distribution through Health Centres the Committee stated,
28 in part: "If Health Centres were to take over N.H.S.
29 dispensing, the patients or those who fetch their
30 medicines would, in many instances, have to travel long
distances. The alternative of small dispensaries as
widely scattered as retail pharmacies would be hopelessly



Hughes

1945

Q. Now, has there been any

experience with the Alameda Institution?

A. Yes, I have heard of some.

Q. Is it operating?

A. I don't know; I don't know.

Q. Now, is it in effect had brought

forward any experience?

A. I don't know; I don't know.

Q. The entire point --

(iii) Pharmaceutical benefits should be

extended to all patients in the hospital (for hospital

and this is the case, especially for patients

outside hospitals). Proposals are sometimes made that

medicines should be purchased centrally and distributed

by a government agency, or alternatively that distrib-

ution to patients be through chemistries established

in clinics or in "health centres". All aspects of the

provision of pharmaceutical benefits were considered in

the White Paper on the subject, in connection with government

and medicine and distribution of medicines reported, in

part, "the need for a central agency to co-ordinate the

supply of medicines and to control the expenditure on

medicines, and to control the supply of medicines in

the country, and to control the supply of medicines in

the country, and to control the supply of medicines in

the country, and to control the supply of medicines in

the country, and to control the supply of medicines in

the country, and to control the supply of medicines in

the country, and to control the supply of medicines in



1
2
3
4 expensive The large number of retail pharmacies
5 is only economically possible because two-thirds of their
6 turnover is obtained from ordinary business and only
7 one-third from N.H.S." The Committee, therefore, con-
8 cluded: "There is no satisfactory alternative to the
9 present system of supplying National Health Service
10 medicines through the established retail channels. If
11 purchase and distribution of medicines were undertaken
12 centrally or through Health Centres costs would increase."

13 (iv) Pharmaceutical services we suggest
14 should be paid for on the basis of a professional fee
15 plus the actual cost of the medicine to the pharmacist.

16 On this basis the charge for more expensive medication
17 would be significantly reduced while the charge for
18 prescriptions containing inexpensive drugs would be
19 modestly increased. This method is sound because it
20 recognizes that the service rendered by the pharmacist
21 through interpreting and dispensing each prescription
22 requires the application of a broad scientific training
23 as well as professional experience and sound judgment.
24 It also recognizes that the professional service is not
25 a function of the cost of the drugs used. Neither the
26 extent and quality of the skill and knowledge nor the
27 degree of responsibility in compounding a prescription
28 can be regarded as a function of the cost of the
29 ingredients.

30 I know, sir, when we suggest this
right away one thinks of how this would have an effect
on an average. Various studies that have been made in
an informal way suggests it would have little effect
over all. It would naturally depend upon any given



included: "There is no
 present system of applying National Health Service
 medicines through the establishment.
 generally on three health centres costs which increase
 in medical services we suggest
 the
 to the pharmacist.
 on this basis the charges for more expensive medication
 would be significantly reduced while the charge for
 prescriptions containing inexpensive drugs would be
 modestly increased. This method is sound because it
 recognizes that the service rendered by the pharmacist
 through interpreting and dispensing each prescription
 requires the application of a broad scientific training
 as well as professional experience and sound judgment.
 It also recognizes that the professional service is not
 a function of the cost of the drugs used. Whether the
 extent and quality of the skill and knowledge required
 degree of responsibility in compounding a prescription
 can be regarded as a function of the cost of the
 ingredients

I know, sir, what we suggest this
 plant away one third of cost this would have an effect
 on an average. Various studies that have been made in
 an informal way suggest it would have little effect
 on the demand for drugs. It would naturally demand some extra



Hughes

9950

sample, the percentage of the medication on higher cost compared to the percentage on the lower cost.

THE CHAIRMAN: This would be a marked departure from the present method?

DEAN HUGHES: At the present time it is a matter of mark-up plus a nominal fee.

THE CHAIRMAN: You would charge the appropriate professional fee, you would recommend the charging of a professional fee?

DEAN HUGHES: That is right.

THE CHAIRMAN: On top of actual cost?

DEAN HUGHES: That is right, sir, and then the only added cost would be the cost of the ingredients used, the invoiced cost to the pharmacist.

COMMISSIONER McCUTCHEON: How about the cost of packages?

DEAN HUGHES: That would be part of the cost, sir, yes.

COMMISSIONER McCUTCHEON: Small packages?

DEAN HUGHES: Small packages.

COMMISSIONER McCUTCHEON: That the pharmacist has to put the material in, that would be part of the cost?

DEAN HUGHES: That is right, sir.

COMMISSIONER McCUTCHEON: What about inventorial losses on expensive drugs?

DEAN HUGHES: The professional fees would be adequate to cover the operation of the dispensary.



as far as the percentage of the production in other cases compared to the percentage in the lower cost.

marked departure from the present method.

is a matter of mark-up or a capital fee.

THE CHAIRMAN: You would charge the

an original professional fee, you would recover the

charge of a professional fee?

THE CHAIRMAN: That is right.

THE CHAIRMAN: On the actual cost?

THE CHAIRMAN: That is right, sir, and

that the only added cost would be the cost of the

materials used, the increased cost to the pharmacist.

COMMISSIONER McCORDON: How about

the cost of postage?

THE CHAIRMAN: That would be part of

the cost, sir, yes.

COMMISSIONER McCORDON: That is

pharmacist has to add the material in, that would be

part of the cost.

THE CHAIRMAN: That is right, sir.

COMMISSIONER McCORDON: What about

insurance to cover the expense of the

of the pharmacist?

would be required to cover the operation of the



Hughes

9951

1
2
3
4 COMMISSIONER McCUTCHEON: The professional
5 fee on drugs that cost a dollar, if you are going to
6 take care of a loss, it would be high?

7 DEAN HUGHES: We naturally have thought
8 how much this fee would be.

9 COMMISSIONER McCUTCHEON: Any
10 suggestions?

11 DEAN HUGHES: Perhaps Professor Fuller
12 would. He is the one who was the father of this
13 proposal several years ago.

14 PROFESSOR FULLER: At the time I first
15 suggested this plan I just reached in the sky and took
16 \$2.00, and then later in 1957 I analyzed 42,000
17 prescriptions dispensed in Canada during the first 16
18 days of November, 1957 to see how it would apply. The
19 42,000 prescriptions were classified at 50-cent intervals,
20 price intervals, up to fifty, fifty-one cents to a
21 dollar and so on. Every province except British
22 Columbia was in the survey. We found that about 46% of
23 the prescriptions were dispensed at out-of-pocket
24 losses. 1.1% of the prescriptions were over \$10.00.
25 The vast majority of the prescriptions dispensed were
26 around, well under \$3.50. The average prescription
27 price of the 42,545 prescriptions was \$2.82. 68.8% of
28 these prescriptions were dispensed at \$2.81 or lower.
29 It is the distribution at different levels rather than
30 the average prescription price which to me is very
significant. There were over 10% of the prescriptions
dispensed at average price of 89¢; under 18% at \$1.35;
under 17% at \$1.82. These lower priced prescriptions



...the ...
 ...it ...
 ...it ...
 ...the ...
 ...how much this ...

...

...would. He is the one who ...
 ...proposed several years ago.

...At the time ...
 ...reached in the ...
 ...and then later ...
 ...prescriptions dispensed in ...
 ...days of November, ...
 ...were classified at 70-cent ...
 ...up to fifty, fifty-one cents to a ...
 ...dollar and so on. Every province except ...
 ...we found that about 45% of ...

...losses. 11% of the prescriptions were over \$10.00.
 ...The vast majority of the prescriptions dispensed were
 ...around, well under \$5.00. The average prescription
 ...of the 42,000 prescriptions was \$3.52. 68% of
 ...these prescriptions were dispensed at \$2.01 or lower.
 ...it is the distribution of different levels rather than
 ...the average prescription price which to me is very
 ...important. There were over 1/3 of the prescriptions
 ...dispensed at average price of \$2.01. Under \$2 at \$1.01
 ...These lower priced prescriptions



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Hughes

9952

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

were actually, the pharmacists were actually losing
money dispensing them.



were actually, the individuals were actually lost
money, disorganized, etc.



1

SS 2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

COMMISSIONER McCUTCHEON: Did you come to a conclusion as to what the professional fee should be?

PROF. FULLER: I have made several studies and I find the actual cost in money is somewhere between \$1.15 and \$1.25 depending upon the location, the Province and a number of other factors. I suggest the pharmacist add to that a sufficient amount for himself and arrive at his own professional fee and that it will be around \$2.00.

COMMISSIONER McCUTCHEON: That inevitably means that the great majority of individual prescriptions are going up in price on the figures you have given us?

PROF. FULLER: The low-priced ones.

COMMISSIONER McCUTCHEON: The low-priced ones in number are the majority?

PROF. FULLER: Yes. The pharmacists are now subsidizing them by the sale of other things what he makes on other higher-priced prescriptions and that does not seem to be equitable.

COMMISSIONER McCUTCHEON: What have the Canadian Pharmaceutical Association or the Ontario Retail Pharmacists' Association to say about this?

DEAN HUGHES: They will be presenting a brief and it may be better to ask them.

PROF. FULLER: This method of prescription pricing is in vogue in several thousand pharmacies in the United States and several dozen in Toronto and a considerable number of other places in Ontario. This is the basis for it. Between the Welfare Department of the

to a condition as to what the professional fee should be
 1911, PHILLIPS: I have made several

studies and I find the actual cost in money is somewhere
 between \$1.00 and \$1.50 depending upon the location, the
 province and a number of other factors. I suggest this
 should be set at a sufficient amount for himself
 and arrive at his own professional fee and if it will
 be around \$1.00.

COMMISSIONER W. H. MONTGOMERY: That invest-
 ibly means that the great majority of individual prescribers
 there are going to be on the figures you have given
 as?

1911, PHILLIPS: The low-priced ones
 1911, PHILLIPS: The low-

priced ones in number are the majority

1911, PHILLIPS: Yes. The physicians

are not as willing then by the sale of other things
 when he makes on other higher-priced prescriptions and
 that does not seem to be equitable.

1911, PHILLIPS: Yes. The physicians

association in the medical association or the Ontario Medical

Association, Association to say as in this

1911, PHILLIPS: They will be over-riding

a price and it may be better to ask them

1911, PHILLIPS: This method of prescribing

that thing is in vogue in several thousand pharmacies
 in the United States and several dozen in Ontario and a
 considerable number of other places in Canada. This is
 the basis of it. Between the volume of business a



Fuller 9954

State of New Jersey and the New Jersey State Pharmaceutical Association bargaining is taking place and in other States in the United States for a prepayment plan using the fee concept as a basis for beginning.

COMMISSIONER McCUTCHEON: Could we have a copy of the study which you made and to which you have been referring?

PROF. FULLER: Yes.

-----EXHIBIT NO. 273C: Copy of study.

DEAN HUGHES: The final point is simply respecting any deterrent charge, if such should be necessary it should be instituted at the commencement of the plan rather than later on. I suppose you know that the Hinchcliffe Report did not like the deterrent charge and they hope that it will be possible to regulate the quantity of the prescription and in this way they could do away with it. Thank you very much.

COMMISSIONER McCUTCHEON: If you limit the quantity of the prescription and the number of times it may be refilled by law, do you not destroy your previous suggestion that no plan should affect the professional judgment of the prescriber?

DEAN HUGHES: But we can qualify it by saying --- number C with respect to limiting of quantity.

COMMISSIONER McCUTCHEON: I am just coming back to that, are you not imposing a decided arbitrary judgment against the judgment of the physician

---EXHIBIT 100---



Hughes 9955

or the dentist if you limit either the amount that may be prescribed or the number of times a prescription can be refilled?

DEAN HUGHES: In one sense it would seem to be that, but you could always order it again as a new prescription.

COMMISSIONER McCUTCHEON: Actually write out a new prescription?

DEAN HUGHES: Yes.

COMMISSIONER McCUTCHEON: That is the trouble you get into with these superimposed orders.

DEAN HUGHES: At the present time that is the same with all prescriptions for drugs, your prescription must be issued, for many of them, each time.

COMMISSIONER McCUTCHEON: Just a minute, can't I get a prescription for drugs and have a notation from the physician that that can be renewed from time to time?

DEAN HUGHES: For a certain specified number of times for some drugs and with others ---

COMMISSIONER McCUTCHEON: It varies?

DEAN HUGHES: Yes.

COMMISSIONER FIRESTONE: Dean Hughes, this has been a very thoughtful statement and we are very grateful to you. Dealing with this very important problem of prepayment of drugs in Canada, do I understand the essence of this statement is that you are recommending a comprehensive prepaid plan for Canada for the provision of prescribed drugs?

DEAN HUGHES: I think our view is we



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

Pages 3255

on the dentist if you limit either the amount that may
be prescribed or the number of times a prescription can
be refilled.

DEAN HUGHES: In one sense it would
seem to be that, but you could always order it again as a
new prescription.

COMMISSIONER MONTGOMERY: Actually

write out a new prescription?

DEAN HUGHES: Yes.

COMMISSIONER MONTGOMERY: That is the

route you get into with these superimposed orders.

DEAN HUGHES: At the present time that

is the same with all prescriptions for drugs, your prescrip-
tion must be issued, for many of them, each time.

COMMISSIONER MONTGOMERY: Just a minute

can't I get a prescription for drugs and have a notation
from the physician that that can be renewed from time to

DEAN HUGHES: For a certain specified

number of times for some drugs and with others ---

of course

COMMISSIONER FERGUSON: Dean Hughes,

this has been a very thoughtful statement and we are very
grateful to you. Dealing with this very important problem

of payment of drugs in Canada, do I understand the
essence of this statement is that you are recommending a
comprehensive prepaid plan for Canada for the provision

of prescribed drugs?

DEAN HUGHES: I think our view is w



Hughes

9956

have not stated that. Our view is if there is to be a comprehensive medical care plan, in our view, it should include drugs.

COMMISSIONER FIRESTONE: As an essential adjunct to such a plan?

DEAN HUGHES: That is right.

THE CHAIRMAN: Thank you very much, Dean Hughes and your associates for your submission and the discussion we have had. We will rise now until two o'clock.

---Luncheon Recess.

have not stated that. My view is if there is to be a
comprehensive revision of the plan, in our view, it should

be done in a comprehensive manner. As an essential

adjunct to such a plan

and it is right

that you very much

been higher and your associates for your suggestion and
the discussion we have had. We will rise now until two



--- On resuming at 2 p.m.

THE SECRETARY: The next submission, Mr. Chairman, will be that of the School of Hygiene, University of Toronto, known as Exhibit 274, and Dr. Rhodes will present his group, and read the summary to the members.

--- EXHIBIT NO. 274: Submission of the School of Hygiene, University of Toronto.

SUBMISSION OF THE SCHOOL OF HYGIENE,
UNIVERSITY OF TORONTO.

Appearances: Dr. A.J. Rhodes
Prof. M.H. Brown
Dr. J.E.F. Hastings

DR. RHODES: Mr. Chairman, members of the Commission, this is a great privilege to appear before you this afternoon. On my right is Milton Brown, Professor of Public Health, and on my left, Dr. John Hastings, Associate Professor of Public Health, both in the School of Hygiene.

I will read our conclusions and recommendations. The conclusions first.

(1) The School of Hygiene has an interest in many aspects of the health services of Canada that come under the terms of reference of the Royal Commission on Health Services, and submits in this brief some facts, comments, and observations which it is hoped may be of some assistance to the Commission in its important task.

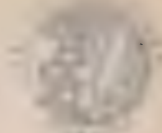


Rhodes

9958

Under the heading of: (2) Graduate Education in Public Health. The School has provided educational facilities for 1,207 professional public health workers in the last 35 years, including physicians, veterinarians, dentists, medical bacteriologists, hospital administrators, health services administrators, statisticians, nutritionists, nurses, health educators, and public health engineers. Most of the graduates are employed on a full-time salaried basis in government departments, hospitals, laboratories, voluntary health agencies, the armed forces or industry. Study of the province of residence of 993 graduates of our diploma courses, 1912 - 1961, shows that 37.6% came from Ontario (373), 45.7% from provinces other than Ontario (454), 13% from many overseas countries (129), and 3.7% from the United States of America (37 persons). In the current session, and this is in line with what the President said this morning, the enrolment of overseas graduates rose to 27.5%. The School of Hygiene thus serves as the Public Health "Staff College" for English-speaking Canada, and must be regarded as in part a national and not only as a provincial institution.

(3) Our present diploma and degree courses, eleven in number, have provided a satisfactory professional education for specialists in many branches of public health and administrative work. Expansion of the teaching program is, however, urgently needed to keep abreast of modern developments in the basic sciences of public health and in the administrative disciplines. The need for an expansion of teaching is most acute in



Under the heading of (3) Graduate

Education in Public Health. The School has provided

educational facilities for 1,100 professional public

health workers in the last 10 years, including physicians

hospital administrators, health services administrators,

and public health engineers. Most of the graduates are

employed on a full-time salaried basis in government

departments, hospitals, laboratories, voluntary health

agencies, the armed forces or industry. Study of the

province of residence of 993 graduates of our diploma

courses, 1915 - 1961, shows that 37.5% came from

Ontario (373), 45.7% from provinces other than Ontario

(454), 13% from many overseas countries (119), and 3.7%

from the United States of America (37 persons). In the

current session, and this is in line with what the

President said this morning, the enrollment of overseas

graduates rose to 34.6%. The School of Hygiene and

as well as the Public Health "Royal College" for British

speaking Canada, and must be regarded as in part a

national and not only as a provincial institution.

(4) Our present diploma and degree

courses, eleven in number, have provided a satisfactory

professional education for specialists in and branches

of public health and administrative work. Expansion of

the existing program is, however, a matter needed to

keep abreast of modern developments in the basic sciences

of public health and in the administrative techniques

of public health and in the administrative techniques



Rhodes

9959

the important field of Health Services Administration. There is also a need for a special course in Tropical Public Health for the many overseas physicians who come to the School, and for Canadians going to the tropics. Medical Virology is another field in which a new course should be offered. We are of the opinion that, in order properly to discharge our responsibilities for the graduate education of public health workers to the Dominion Government and to the Provinces of Canada, substantial assistance from federally administered funds is essential, and specific recommendations are made later in the brief.

On the subject of bursaries: (4) The bursary program of the National Health Grants has greatly assisted professional education in public health, but review of the situation over the last few years leads us to the conclusion that stipends should be increased, and a scale should replace the present "flat-rate" system of payment. Stipends at the higher end of the scale would encourage senior workers to return to the university for advanced study. It is also concluded that the National Health Grants program would better encourage recruitment to public health if some bursaries could be awarded directly to candidates chosen by our School of Hygiene rather than the Provincial Departments of Health. Such candidates would be encouraged to enter the universities to teach and conduct research in public health, preventive medicine, hospital administration, and health services administration. There is a great shortage of able applicants for such posts in Canada.



Rhodes

9960

(5) Continuing Education for Public Health Workers. During the last five years, the School has provided a series of "Refresher Courses" in Public Health and in Industrial Medicine for physicians and other health workers. These usually lasting from three to five days' duration, have been attended by over 300 persons from all of the Provinces. We welcome, and accept, this responsibility for the continuing education of professional public health workers, and are convinced of the value of such a program.

(6) Undergraduate Instruction. The School provides instruction each year to about 1,200 undergraduate students registered in nine different divisions of the University of Toronto, many of whom eventually enter the various health professions. This is an important endeavour and should be continued.

(7) Research is a major interest of the Staff and of those graduate students who register each year for the degrees of Ph.D. and M.A. in the basic sciences taught in the School - bacteriology, immunology, virology, parasitology, physiology, nutrition, and public health. The research funds provided through the National Health Grants program of the Department of National Health and Welfare, in collaboration with the Department of Health for Ontario, have been invaluable in developing our research program. However, we feel that it should be possible for a national body such as our School to be able to submit certain projects directly to Ottawa, if the subject is outside the specific interest of Ontario. The National Health research

Health Services. During the last few years, the Government has provided a series of "strengthened courses" in public health and in industrial medicine for physicians and

to these days, however, have been attended by over 100 persons from all of the Provinces. As welcome, and except, this response shows how the continuing education of professional public health workers, and the conviction of the value of such a program.

(3) University Education

School provides instruction each year to about 1,200 undergraduate students registered in nine different divisions of the University of Toronto, many of whom

is an important element and should be continued. Research is a major interest of

the staff and of those graduate students who register each year for the degrees of Ph.D. and M.A. in the field of sciences taught in the school - bacteriology,

immunology, virology, parasitology, physiology, nutrition,

and public health. The research funds provided through

the National Health Institute program of the Government of

National Health and Welfare, in collaboration with the

Department of Health for Ontario, have been invaluable in

developing our research program. However, we feel that

it should be possible to do a lot more work as a

school to be able to submit certain projects first in

to Ottawa, if the subject is outside the specific

interest of Ontario. The National Health Research



Rhodes

9961

program should not, in our opinion, be merged with the Medical Research Council, for it has a different purpose. The National Health Grants funds should be used more than at present to encourage and support research concerned with in certain specific area, for example:

(a) the development of more effective measures of health status than now exist;

(b) the application of the epidemiologic method to a wide range of noninfectious diseases and disabilities;

(c) the trial on a pilot basis of new methods of providing health services to communities;

(d) as well as the development of methods for evaluating health services.

One of the main reasons why more has not been done in these four fields is the shortage of competent persons trained in research methods.

(8) Consultation in Health Services.

We note and commend the interest of many health authorities in Canada in submitting their public programs to critical study and evaluation. Several senior members of our staff have been made available for carrying out such surveys of health programs. They have made a study of the program of the Nova Scotia Department of Public Health, a study of the health services of several overseas countries, and a survey of the work of over 100 health departments of Canada, the latter by means of a questionnaire. We submit that this type of

Programs... be merged with the
 Medical Research Council, for it has a different program
 the National Health Research Council should be used more
 of present to conduct and support research
 in certain medical areas, for example:
 (a) the development of more effective
 measures of health status than for

- (b) the application of the epidemiologic
 logic to a wide range of non-infectious
 diseases and disabilities;
- (c) the trial on a pilot basis of new
 methods of providing health services
 to communities;
- (d) as well as the development of

one of the main reasons why more has not been done is
 that the field is the shortage of competent persons
 trained in research methods.

(8) Local Action in Health Services
 It must be pointed out that the interest of many health authorities
 lies in Canada in emphasizing their public programs to
 medical study and education. Several recent inquiries
 of our staff have been made with reference to carrying out
 some surveys of health programs. They have made a study
 of the program of the Nova Scotia Department of Health
 and a study of the health services of several
 other provinces, and a survey of the work of over
 100 health departments in Canada, the last two years
 a questionnaire. We want to know this type of



Rhodes

9962

1
2
3 evaluation should be conducted regularly by official
4 health departments, as well as by voluntary health
5 agencies.

6 (9) The Role of the Public Health

7 Services is one of the special interests of the
8 University of Toronto, which has provided English-
9 speaking Canada with Medical Officers of Health,
10 hospital administrators, and other professional health
11 workers since 1912. The Staff of the School has always
12 made a point of keeping in close touch with the public
13 health programs of the Dominion Government and the Provin-
14 cial Governments, as well as with the activities of the
15 "grass roots" local health departments, in which so many
16 of our graduates serve. We submit that the concept of
17 a local health department directed full-time by a public
18 health trained physician, to serve every Canadian
19 community in the "settled" areas is basically sound,
20 and of proven usefulness. In the interests of the health
21 of the Canadian people, every effort should be made to
22 establish such departments of health in areas where they
23 do not now exist.

24 (10) Local Health Departments are

25 providing, and on a very economical basis, a wide range
26 of effective promotional and preventive health services,
27 and are also usefully engaged in diagnostic, curative
28 and rehabilitative work in infectious and certain
29 chronic diseases, and in certain disabling conditions
30 It seems to us, however, that much more use could be
made of the skills of the Medical Officer of Health and
of his colleagues, the public health veterinarian,



evaluation of the work of the health department, as well as its voluntary health agencies.

(b) The Role of the Health Department

Health is one of the greatest interests of the University of Toronto, and has provided English-speaking Canada with many gifts of health, hospital administration, and other professional health workers since 1912. The School has always made a point of keeping in close touch with the health programs of the Dominion Government and the Provincial Governments, as well as with the activities of the "Public Health" local health departments, in which it has an important part. The School has the concept of a local health department as a model for a public health training program, to serve every Canadian community in the "natural" areas is usually seen, and of public health. In the interests of the public or the Canadian people, every effort should be made to establish and department of health in areas where they do not now exist.

(c) Local Health Departments

Providing, as on a very economical basis, a wide range of services, preventive and curative health services, and are also engaged in education, research, and other activities. In addition, they are also engaged in certain administrative functions, and in certain administrative functions. However, that which they are doing in the field of the health of the people, and the health of the people, and the health of the people.



Rhodes

9963

dentist, and nurse. The Health Officer is a physician with a wide experience of medicine, and additional qualifications in the specialty of Preventive Medicine. He practises this specialty by applying knowledge about health and disease through organized community action. The public health physician has, in our opinion, a clear responsibility to do all in his capacity, consistent with his human and financial resources, to promote, protect, and restore the health of the members of his community. Despite a generally favourable state of the public health, great tasks in prevention and control of public health problems still face most local health departments in Canada. Fields in which progress has been slow include the sanitary control of air, water and foodstuffs; the hygiene of restaurants, food stores, public washrooms, camps and swimming pools; housing; rehabilitation; accident prevention; and organized home care for the sick or the elderly. Much remains to be done in these areas. In order to carry forward energetically programs for the betterment of the health of the Canadian people, the Medical Officer of Health of each community should be specifically designated as coordinator of all community health services, including rehabilitation, chronic disease, and organized home care programs. No other member of the community has such a wide range of qualifications for this role.



(11) The School of Hygiene has presented formal graduate instruction in Health Services Administration since 1949, and members of the staff have conducted research in several aspects of this subject. Accordingly, this brief discusses the question of a comprehensive health service for Canada. Discussion of any such plan must take into account the considerable changes that are occurring and will continue to occur in medical, hospital, and public health practice as a result of the great scientific and technological advances in the health and biological sciences. These advances have led to a change in the overall pattern of disease. There has been a great fall in mortality rates in the younger and middle aged groups, largely because of less communicable disease, so that more people are reaching middle and old age. Many of the diseases in these age groups, in distinction to the communicable diseases, are chronic and prolonged, and make heavy demands on the medical team for diagnosis, therapy, and rehabilitation.

(12) The trend to-day in medical practice is increasingly towards specialization, and the modern specialist usually has a satisfying job with good facilities. The general practitioner, however, tends to be isolated from the main stream of medical advance. He finds it difficult to keep up-to-date. He has to refer many patients to specialists and hospitals for diagnosis and treatment, because he is unable to provide facilities for the elaborate diagnostic methods of modern medicine. Increasingly, he is becoming a



(11) The School of Hygiene has

presented formal graduate instruction in Health Services Administration since 1945, and members of the staff have conducted research in several aspects of this subject.

Accordingly, this brief discusses the question of a

College of Health Services for Canada. Discussion

of any such plan must take into account the considerable changes that are occurring and will continue to occur in medical, hospital, and public health practice as a result of the great scientific and technological advances in the health and biological sciences. These advances have led to a change in the overall pattern of disease. There has been a great fall in mortality rates in the younger and middle aged groups, largely because of less communicable disease, so that more people are reaching middle and old age. Many of the diseases in these age groups, in distinction to the communicable diseases, are chronic and prolonged, and make heavy demands on the medical team for diagnosis, therapy, and rehabilitation.

(12) The trend today in medical

practice is increasingly towards specialization, and the modern specialist usually has a satisfying job with good facilities. The general practitioner, however, tends to be isolated from the main stream of medical advance. It is difficult to keep up-to-date. He has to refer many patients to specialists and specialists for diagnosis and treatment, because he is unable to provide facilities for the elaborate diagnostic methods of modern medicine. Consequently, he is becoming a



sign-post to direct the patient to the specialist. We suggest that corporate practice, especially in a group clinic staffed by general practitioners and by specialists, and providing some diagnostic facilities, provides an answer to many of the problems of the general practitioner. The setting of a group clinic is conducive to good quality of medicine, and an extension of this form of practice is in the best interests of the health of the Canadian people.

(13) Increasingly, the physician regards the hospital as the real centre for his scientific medical work. It is only hospitals or large clinics that can provide the full range of specialized and costly equipment needed for diagnosis and therapy, and the extensive technical staff needed to operate these facilities. We feel that these facilities should be available for maximum use by the community, to avoid unnecessary and costly duplication. More use of these facilities should be made on an out-patient basis.

(14) Until recently, there was little effort made to plan the hospital services on a regional basis. This is slowly becoming possible under the various Provincial Hospital Services Commissions. A particular problem in many parts of the country is the small community hospital, understaffed and underequipped for modern medical practice, which finds it difficult to meet the accreditation standards.

(15) It is essential that hospitals be administered by an adequately trained hospital administrator, and the School of Hygiene will continue to provide graduate instruction in this field to the best of its ability, with



...to assist the patient in the specialist's
...that more are needed, especially in a hospital
...by general practitioners and by specialists
...providing some diagnostic facilities, but as an
...to many of the problems of the general practitioner.
...the setting of a hospital is conducive to good
...of medical, and an extension of this form of
...is in the best interests of the health of the

...It is only hospitals or large
...clinics that can provide the full range of specialized
...and costly equipment needed for diagnosis and therapy,
...and the extensive technical staff needed to operate the
...facilities. We feel that these facilities should be
...available for maximum use by the community, to avoid
...unnecessarily and costly duplication. More use of these
...facilities should be made on an out-patient basis.

(iii) Until recently, there was little
...effort made to plan the facilities required on a regional
...basis. It is slowly becoming possible under the various
...provincial medical service commissions. A particular
...question in many parts of the country is the small
...community hospital, which is often under-equipped for
...modern medical progress, which is in a state of
...the accreditation system.
...it is essential that hospitals be
...and the school of medicine will continue to provide training
...in this field to the best of its ability.



1
2
3
4 the financial resources available. In an effort to
5 halt rising costs, some hospitals have adopted the
6 system of "progressive patient care". In this system,
7 patients are grouped according to the degree of severity
8 of the illness and the amount of attention needed.
9 Extension of this system should be encouraged, for not
10 only does it conserve professional and technical help,
11 but it is in the best interests of the patient. There
12 is also a place for the specialized hospital, or unit
13 within a hospital, dealing only with certain categories
14 of illness. These facilities must be available on a
15 regional basis.

16 (16) There is an urgent need for the
17 provision of more beds for chronic long term illnesses,
18 in less elaborately staffed and equipped institutions
19 than the acute general hospital. Other services which
20 assist in lightening the load on general hospitals are
21 rehabilitation clinics and home care programmes. These
22 facilities should be extended, and the clinics planned
23 on a regional basis.

24 (17) Voluntary health agencies play an
25 important role in the prevention of disease, and in the
26 care and treatment of the sick and disabled, and
27 should be encouraged. There is, however, a need for
28 co-ordination of these services, one with another and
29 with government departments, for there is often needless
30 duplication, and in some areas a lack of services.

(18) Our objective is a Comprehensive
Health Service which will make it possible for all
Canadians to have the benefits of modern health care,

the financial resources available. In an effort to
help these states, some hospitals have adopted the
system of "progressive patient care". In this system,
patients are grouped according to the degree of severity
of the illness and the amount of attention needed.
Rotation of the system should be encouraged, for not
only does it conserve professional and technical help,
but it is in the best interests of the patient. There
is also a place for the specialized hospital, or unit
within a hospital, dealing only with certain categories
of illness. These facilities must be available on a
national basis.

(16) There is an urgent need for the

creation of more beds for chronic long term illnesses,
in less elaborately staffed and equipped institutions
than the acute general hospital. Other services which
assist in lightening the load on general hospitals are
rehabilitation clinics and home care programs. These
facilities should be extended, and the clinics planned
on a regional basis.

(17) Voluntary health agencies play an

important role in the prevention of disease, and in the
care and treatment of the sick and disabled, and
should be encouraged. There is, however, a need for
coordination of these services, one with another and
with government departments, for there is often needless
duplication, and in some cases a lack of services.

(18) One objective is a comprehensive

health plan which will make it possible for all
members to share the benefits of modern health care.

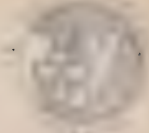


1
2
3
4 without regard to means, age, occupation, or place of
5 residence. We have set out in detail in the body of
6 the brief the basic principles of such a service. In
summary these principles are:

- 7 responsiveness to advances in health sciences
8 and technology;
9 adequacy in numbers of health personnel and
10 facilities;
11 equitable distribution in each province of
12 personnel and facilities;
13 high quality of work;
14 balance among the various components of the service;
15 flexibility of administration to meet the
16 particular needs of each province and region;
17 professional control of matters requiring pro-
18 fessional judgment;
19 and public accountability for general policy;

20 Above all, the Comprehensive Health Service must be
21 dedicated to the improvement of the health of the
22 Canadian people. Administrative and financial considera-
tions must not obscure the essential humane purpose of
the programme.

23 (19) To apply these principles in
24 Canada we propose continuation of the four major existing
25 services - public health services - personal health
26 services - hospital services - and voluntary health
27 agencies. It is proposed that government now accept
28 its full responsibility for health by establishing
29 agencies for personal health services under the juris-
30 diction of each provincial Minister of Health. The



without regard to means, age, occupation, or place of residence. We have set out in detail in the body of the report the basic principles of such a service. In

responsiveness to advances in health sciences and technology;
adequacy in numbers of health personnel and facilities;

equitable distribution in each province of personnel and facilities;
high quality of work;
balance among the various components of the service;

flexibility of administration to meet the particular needs of each province and region;
professional control of matters regarding professional judgment;

and public accountability for general policy;

Above all, the Comprehensive Health Service must be

dedicated to the improvement of the health of the

Canadian people. Administrative and financial considerations must not obscure the essential humane purpose of the program.

(4) To apply these principles in

Canada we propose continuation of the four major existing

services - public health services - personal health

services - hospital services - and voluntary health

services. It is proposed that government now accept

the full responsibility for health by establishing

agencies for personal health services under the jurisdiction of each provincial Minister of Health. The



Rhodes

9968

1
2
3
4 essence of our proposal is that the comprehensive nature
5 of the health services be secured through co-ordination.
6 Government, through commissions or departments of health,
7 will have a direct responsibility for public health
8 services, hospital services, and personal health services.
9 There will, however, still remain a need for co-ordination
10 of these services one with another, and with services
11 provided by the voluntary agencies. This co-ordination
12 will be secured in part by the establishment of a
13 committee representing the various provincial govern-
14 ment departments concerned, and in part by the establish-
15 ment of new statutory bodies known as Provincial
16 Advisory Health Councils. These Advisory Councils
17 would be composed of representatives of government
18 departments concerned with health, representatives of
19 the health professions, voluntary health agencies, the
20 universities and the general public. The Advisory
21 Councils would have powers and facilities to study,
22 review, and report upon major health activities in the
23 Province. In some provinces it would seem desirable
24 to delegate some of these functions to Regional
25 Committees and local health departments.

26 (20) The principles of co-ordination
27 of existing services must operate not only at the local
28 and provincial levels, but should derive substantial
29 leadership from the national government. This co-
30 ordination would be effected in part by interdepartmental
committees at a national level and in part by the
Dominion Council of Health suitably expanded to make it
more representative of the health professions and



Government, through commissions or departments of health, will have a direct responsibility for public health services, hospital services, and personal health services. There will, however, still remain a need for co-ordination of these services one with another, and with services provided by the voluntary agencies. This co-ordination will be secured in part by the establishment of a

committee representing the various provincial government departments concerned, and in part by the establishment of new statutory bodies known as Provincial Advisory Health Councils. These Advisory Councils would be composed of representatives of government departments concerned with health, representatives of the health professions, voluntary health agencies, the universities and the general public. The Advisory Councils would have powers and facilities to study, review, and recommend major health activities in the province. In some provinces it could also be asked to delegate some of these functions to Regional committees and local health departments.

(2) The principle of co-ordination

Existing services must operate not only at the local and provincial levels, but also at the national level.

Co-ordination would be effected in part by inter-departmental committees at a national level and in part by the formation of a health authority expanded to cover the co-ordination of the health professions, and



1
2
3 teaching institutions.

4
5 Recommendations: Under Term of Reference (e): Methods
6 of Providing Adequate Personnel with the Best Possible
7 Training and Qualifications for Such Service

8 (21) In view of the role that the
9 School of Hygiene plays in graduate education, as the
10 Public Health Staff College for English-speaking
11 Canada, it is recommended that a substantial annual
12 grant be made to strengthen the teaching programme.
13 Over 60% of the graduates of the School have come from
14 beyond the Province of Ontario, which fact suggests that
15 the annual grant should be paid from national funds,
16 such as the National Health Grants. The main burden
17 of providing professional education for public health
18 workers for English-speaking Canada has fallen on the
19 University of Toronto for 35 years. This burden should
20 now be shared. It is suggested that the annual subsidy
21 should be at least \$150,000, to permit of the appoint-
22 ment of professorial and supporting technical and
23 clerical staff to provide specialist instruction in
24 many aspects of modern public health. (This would
25 permit of the appointment, on the average, of 10 staff
26 members at a salary of \$12,000 (\$120,000) and of 8
27 supporting staff at a salary of \$3,000 (\$24,000), with
28 \$6,000 provided for supplies and materials.) It is
29 to be understood that this subsidy is requested to
30 permit strengthening of the teaching programme, the
primary function of a Graduate School of Public Health.
It is further recommended that, in recognition of the

...the fact that...

...in view of the fact that the...

School of the same name in graduate education, as the...

Public Health Staff College for English-speaking...

Canada, it is recommended that a substantial annual...

grant be made to strengthen the teaching programme.

Over 50% of the students of the school have come from...

beyond the 12 provinces of Canada which have contributed that...

the annual grant should be paid from national funds,

such as the National Health Act. The main function...

of providing professional education for public health...

workers for English-speaking Canada has fallen on the...

University of Toronto for 25 years. This function should...

now be shared. It is suggested that the annual subsidy...

should be at least \$10,000, or twice of the amount...

now of \$5,000, and appropriate to the national and...

over and over to the specialized institution in...

new aspects of public health. (This would...

benefit of the Government, on the average, at least...

as a result of \$10,000, \$15,000, and of \$...

amounting to a salary of \$10,000, \$15,000, and...

\$20,000 provided for supplies and materials. It is...

to be understood that this salary is suggested as...

per cent replacement of the present program, the...

primary function of a graduate school of public health...

is to further the research that is necessary for the...



1
2
3
4 special contribution of the School of Hygiene to the
5 Health Services of Canada since 1927, a capital grant
6 of approximately \$500,000 be made available to the
7 University of Toronto to rehabilitate and re-equip the
8 35 year old building. (This is a provisional estimate.
9 Detailed planning for rehabilitation of the School building
will only begin in mid-1962.)

10 (22) We submit that without substantial
11 support from federal funds, the teaching programme of
12 our School will become progressively less effective,
13 and as a result the quality of public health workers,
14 hospital administrators, and laboratory scientists will
15 deteriorate, to the ultimate detriment of the health
of the Canadian people.

16 (23) The bursaries of the National
17 Health Grants Programme play an important part in
18 supporting graduate students in public health and
19 hospital administration. Two important changes are
20 recommended in this programme:

- 21 (a) Stipends should be raised, and paid on a
22 scale that is related to the experience and
23 commitments of the students. The suggested
24 scale is from \$300 to \$600 per month. The
25 higher stipends would be offered to senior
26 workers wishing to return to the university
27 for advanced graduate study and research, for
28 example in health services administration,
hospital administration, preventive medicine,
public health, and the various basic sciences.

- 29 (b) It is also recommended that some bursaries be
30



special contribution of the School of Hygiene to the
 health services of Canada since 1927, a capital plan
 of approximately \$1,000,000 be made available to the
 University of Toronto to rehabilitate and re-equip the
 15 year old building. (This is a provisional estimate,
 detailed planning for rehabilitation of the School building
 will only begin in mid-1962)

(22) We submit that without substantial
 support from federal funds, the national programme of
 our school will become progressively less effective,
 and as a result the quality of public health workers,
 hospital administrators, and laboratory scientists will
 deteriorate, to the ultimate detriment of the health
 of the Canadian people.

(23) The purposes of the National
 Health Grants Programme play an important part in
 supporting graduate students in public health and
 hospital administration. Two important changes are
 recommended in this programme:

(a) Stipends should be raised, and paid on a
 scale that is related to the experience and
 accomplishments of the students. The suggested
 scale is from \$350 to \$500 per month. The
 higher stipends would be offered to senior
 workers wishing to return to the university
 for advanced graduate study and research, for
 example in health services administration,
 hospital administration, preventive medicine,
 public health, and the various basic sciences.
 It is also recommended that some provision be



Rhodes

9'971

1
2
3
4 made available for award directly by the
5 School of Hygiene. At the moment, all
6 recommendations have to be made by the
7 Provinces. Such bursaries, under our own
8 direction, would be used to encourage promising
9 candidates to qualify for positions in research
10 and teaching in the School of Hygiene and
11 Departments of Preventive and Social Medicine
12 in the Canadian Medical Schools. The
13 bursaries would also be used for persons
14 interested in research and administrative work
15 in government departments, hospital and other
16 commissions, prepayment plans, and voluntary
17 health agencies.

18 (24) It is recommended that the
19 Commission endorse the principle that public health
20 workers be required to attend "refresher" courses from
21 time to time, to maintain and improve quality of pro-
22 fessional service, and that the School of Hygiene be
23 encouraged to provide this regular programme of
24 continuing education, under a full-time staff member.

25 (25) It is recommended that the
26 National Health Grants programme of the Department of
27 National Health and Welfare should be increased or
28 reorganized so as to permit of additional bursary support,
29 direct support of the teaching programmes of the School
30 of Hygiene, and an expanded programme of research in the
field of public health. We also recommend that research
funds be made available directly to the School of
Hygiene on a project basis, where the project is one



make available for award directly by the
 School of Hygiene. At the moment, all
 recommendations have to be made by the
 provinces. Such referees, under our own
 direction, would be used to encourage private
 candidates to qualify for positions in research
 and teaching in the School of Hygiene and
 Department of "Preventive and Social Medicine"
 in the Canadian Medical Schools. The
 referees would also be used for persons
 interested in research and administrative work
 in government departments, hospital and other
 institutions, prepayment plans, and voluntary
 health agencies.

(14) It is recommended that the

Commission endorse the principle that public health
 workers be required to attend "refresher" courses from
 time to time, to maintain and improve quality of pro-
 fessional service, and that the School of Hygiene be
 encouraged to provide this regular programme of
 continuing education, under a full-time staff member.

(15) It is recommended that the

National Health Grants programme of the Department of
 National Health and Welfare should be increased on
 reorganised so as to permit of additional library support
 direct support of the teaching programme of the School
 of Hygiene, and an expanded programme of research in the
 field of public health. It is also recommended that research
 funds be made available for the School of
 Hygiene on a project basis, where the project is one



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Rhodes

9972

1
2
3
4 of national or international significance, and not
5 of specific interest to the Province of Ontario.
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30



of national or international significance, and not
of specific interest to the Province of Ontario.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100



Recommendations: Under Term of Reference (b): Methods of
Improving Such Existing Health Services

(26) Recognizing that many improvements in the health of the people of Canada could be brought about by application of scientific knowledge now available, the School of Hygiene strongly recommends that a "National Plan for Progress in Public Health" be prepared by the Department of National Health and Welfare in collaboration with the Provinces. The provincial plans would be based on the National Plan, but would differ in details according to the local public health problems. The "National Plan for Progress in Public Health" would specify several major objectives, and would suggest the methods to be used to reach these objectives. The broad "objectives" would include the following:

- (a) A substantial reduction in incidence of the
major communicable diseases for which con-
trol measures are available, especially
tuberculosis, venereal disease, hepatitis,
food-poisoning and other gastro-intestinal
infections, staphylococcal infections, rheu-
matic fever, hospital infections, pneumonia,
whooping cough, influenza, and poliomyelitis.
These reductions would be sought by an in-
tensification of immunization programs at
all ages, a wider free distribution of
biologicals for prevention, an expanded pro-
gram of case-finding, better health education
of the public, a higher standard of hygiene
in hospitals, eating places, and in the



in the health of the people of Canada could be brought

(2) Recognizing that many improvements

in the health of the people of Canada could be brought about by application of scientific knowledge now available

the School of Hygiene strongly recommends that a "National

Plan for Progress in Public Health" be prepared by the

Department of National Health and Welfare in collaboration

with the Provinces. The provincial plans could be based

on the National Plan, but would differ in details according

to the local public health programs. The "National

Plan for Progress in Public Health" would specify several

major objectives, and would suggest the methods to be

used to reach these objectives. The broad "objectives"

would include the following:

(a) A significant reduction in incidence of the

major communicable diseases for which con-

trol measures are available, especially

tuberculosis, venereal disease, hepatitis,

typhoid fever, and other gastro-intestinal

diseases.

(b) A reduction in incidence of the

major chronic diseases, especially

hypertension, heart disease, cancer, and

diabetes.

(c) A reduction in incidence of the

major mental diseases, especially

schizophrenia, manic-depressive psychosis,

and alcoholism.

(d) A reduction in incidence of the



1
2 preparation and marketing of food, and a
3 more vigorous policy of inspection by
4 public health veterinarians and sanitary
5 inspectors.

6 (b) A marked increase in the standards of clean-
7 liness of restaurants. This would be effected
8 by intensification of health education of
9 restaurant staff as well as the general
10 public, more stringent regulations and
11 vigorous enforcement by sanitary inspectors.

12 (c) A substantial improvement in the standards
13 of hygiene of meat, milk, raw and processed
14 foods. This objective can only be reached
15 following agreement between the government
16 departments now concerned, e.g., the Federal
17 and Provincial Departments of Agriculture
18 and of Health, and the various municipal
19 governments. Passage of necessary legisla-
20 tion must be followed by strict enforcement
21 of standards by public health veterinarians
22 and sanitary inspectors.

23 (d) A reduction in pollution of lakes, rivers,
24 and surface waters, by enforcement of regu-
25 lations about sewage disposal, discharge of
26 industrial wastes, and septic tanks.

27 (e) A reduction in pollution of air by smoke,
28 fumes, and industrial processes. This may
29 require passage of legislation and enforce-
30 ment.

(f) Elimination of scurvy and other deficiency
diseases, and an improvement in dietary
habits of certain people in the population,



1
2 the obese, school children, and expectant
3 mothers. These objectives would be reached
4 in the main by improved health education of
5 the general public and specific segments of
6 the community. Public health nutritionists
7 and dietitians are playing a major role.

8 (g) A reduction in the incidence of dental decay
9 and other manifestations of dental ill-health
10 in children. This would be attempted by
11 making determined efforts to improve dental
12 public health programs by the training of more
13 public health dentists and dental hygienists,
14 by the greater use of dental hygienists, by
15 improved health education, and by widespread
16 adoption of fluoridation of community water
17 supplies.

18 (h) A reduction in the gross wastage of life from
19 home, industrial, recreational, and automo-
20 bile accidents. The immediate program needed
21 here is one of fact-finding into causation,
22 to be followed by suitable control measures,
23 and legislation where indicated.

24 (i) Reduction in disability from chronic diseases,
25 another objective by the more adequate pro-
26 vision of community facilities for the
27 rehabilitation of the disabled and chronically
28 ill, with the local health department play-
29 ing a coordinating role.

30 (j) The final objective we have spelled out.
31 Reduction in the need for hospital care,
32 by a wider use of organized home care and
33 home nursing programs, under the aegis of
34 the health department.



the cases, cases, children, and experience
 to be. These are activities which are possible
 in the field by limited health education of
 the general public and specific segments of

playing a major role.

(3) A reduction in the incidence of dental disease
 and other oral conditions of dental ill-health
 in children. This would be attempted by
 making certain all efforts to improve dental
 health. Health programs in the training of dental
 public health dentists and dental hygienists
 by the presence of dental hygienists, by
 improved oral education, and by widespread
 adoption of the use of community water
 supplies.

(4) A reduction in the cases of life-threatening
communicable diseases, such as tuberculosis, and
other diseases. The immediate purpose would
 be to reduce the incidence of these diseases,
 to be followed by suitable control measures,
 and education about the diseases.

(5) Reduction in the incidence of chronic diseases
 another objective of the same general program
 would be to reduce the incidence of these diseases
 by the reduction of the physical and emotional
 stress, with the local health department playing
 a major role.

The final objective we have stated is
to reduce the incidence of cancer
 by the use of appropriate measures and
 some form of control, and in the early stages
 the local health department.



(27) As part of each "Provincial Plan for Progress in Public Health" as described, it is recommended that the duties of the Medical Officer of Health be redefined so as to emphasize his primary responsibility for the health of his community. In particular, it is recommended that the Medical Officer of Health be, by statute, a member of the Medical Staff of each general hospital in his community, and a member of the board of each voluntary health agency or health council in his area.

(28) In order to facilitate the work of public health officials and others interested in the overall incidence of disease and disability, it is recommended that the collection and analysis of vital statistics including morbidity and mortality be improved, and that the statistics be distributed to provincial and local departments of health as soon as possible as a basis for planning and action.

(29) To further assure the attainment of the objectives of the "National Plan for Progress in Public Health", health departments under a full-time public health trained physician should be established in those areas of each province where they do not now exist. Part-time health officers should take formal training leading to the award of the Diploma in Public Health or be replaced.

(30) It is recommended that the development of the "National Plan" as we have called it, and the various provincial plans should begin as soon as possible. Many of the objectives could be reached by 1967, the centennial of Confederation.



(17) The part of each "National Plan for Progress in Public Health" as required, it is recommended that the same be placed in the hands of each member of the board of health, by which the health of the community is maintained, it is recommended that the board of health be, by statute, a member of the board of each general hospital in the community, and a member of the board of each voluntary health agency or health council in the area.

(18) In order to facilitate the work of public health officials, and others interested in the improvement of the community and the health of the people, it is recommended that the collection and analysis of vital statistics including morbidity and mortality be improved, and that the same be distributed to hospitals and local departments of health as soon as possible as a basis for planning and action.

(19) To further assure the attainment of the objectives of the "National Plan for Progress in Public Health", the Government should establish a health training program which is equivalent to those areas of each province, and that it be now established. The health of each province should be improved, and the health of the community should be improved, and the health of the community should be improved.

(20) It is recommended that the Government of the "National Plan" as we have called it, and the various provincial plans which have been established, be of the objectives which are set forth in the National Plan of the Government.



1
2
3
4 Certain Recommendations: Under Terms of Reference (b) and
5 (c), methods of improving and correlating existing
6 services with a view to providing improved health services

7 (31): To meet the changing conditions of
8 medical and hospital practice in Canada, we recommend a
9 Comprehensive Health Service, administered in each
10 Province by the Minister of Health, and including as three
11 separate branches, public health, hospital, and personal
12 health services. Government already accepts responsibility
13 for public health and hospital services, and it should
14 now accept its full responsibility by establishing agencies
15 for personal health services.

16 (32): Each provincial government should
17 establish, according to its own particular pattern, a
18 Personal Health Services Agency concerned with the plan-
19 ning, administration and financing of personal health
20 services. The responsibility of these agencies would be
21 to assure that personal health services of high quality are
22 provided to all residents without regard to means, age,
23 occupation, or place of residence. The Personal Health
24 Services Agency should be administered by commissioners
25 representative of the general public as well as the
26 professional and technical groups concerned. In the
27 larger provinces, the agency could be known as the Personal
28 Health Services Commission, equal in status to the Hospital
29 Services Commission and the Department of Public Health.
30 In the smaller provinces, the agency might well be a
division in the Department of Public Health, as is the
case with the hospital program. The personal health services
agencies must have financial resources to enable them to
fulfill their responsibilities.



in accordance with the provisions of the Act.

to view the situation in the light of the health services

to meet the changing conditions of

medical and hospital services in Canada, we recommend a

Co-ordinative Health Service, administered in each

Province by the Minister of Health, and including as three

separate branches, public health, hospital, and personal

health services. Government already has the responsibility

for public health and hospital services and it should

now accept the full responsibility for establishing agencies

for personal health services.

(2) That a central government should

establish, according to its own particular pattern, a

Personal Health Services Agency concerned with the planning,

administration and financing of personal health

services. The responsibility of these agencies would be

to assure that persons have the services of high quality and

provided to all residents without regard to income, age,

occupation, or place of residence. The Personal Health

Services Agency should be administered by commissioners

representative of the general public as well as the

professional and technical groups concerned. In the

larger provinces, the agency could be known as the Personal

Health Services Commission, and in others as the Health

Services Commission and the Department of Public Health.

In the smaller provinces, the agency might well be a

division of the Department of Health, as is the



1
2
3
4 (33) On the subject of coordination, the
5 three official branches of the Comprehensive Health Ser-
6 vice must be closely coordinated at the national, provin-
7 cial, regional, and local levels, and should work in close
8 relationship with official welfare services and with the
9 non-government health and welfare agencies.

10 (34) In order to assist the Health Service
11 to be truly comprehensive, at the national level the
12 membership of the existing Dominion Council of Health
13 should be expanded to include representatives of the
14 major health professions, university divisions in the
15 health sciences, the two Canadian Schools of Hygiene, and
16 the public. The functions of the Dominion Council of
17 Health as expanded should include

18 consideration of any proposed new legislation or
19 proposed changes in health legislation;
20 making of recommendations to the Minister of
21 National Health and Welfare or any other Ministers
22 about any matter affecting the health of the
23 Canadian people;
24 development of close relationships between govern-
25 ment and non-government health services;
26 scrutiny of any non-government agency seeking
27 incorporation.

28 (35) In addition to the Dominion Council
29 of Health, also at the National level there should be a
30 permanent committee of representatives of the Department
of National Health and Welfare and other departments con-
cerned with matters of health. The functions of this
committee should include:



(13) On the subject of coordination, the three official branches of the Commonwealth Health Service will be closely coordinated at the national, provincial, regional, and local levels, and should work in close relationship with official welfare services and with the non-government health and welfare agencies.

(14) In order to assist the Health Service to be truly comprehensive, at the national level the

should be expanded to include representatives of the health professions, university divisions in the health sciences, the two Canadian schools of hygiene, and the public. The functions of the Dominion Council of Health as expanded should include

consideration of any proposed new legislation or proposed changes in health legislation.

Review of the responsibilities of the Minister of

National Health and Welfare and other Ministers

about an agency affecting the health of the

development of close relationships between govern-

ment and non-government health agencies.

Review of any non-government agency working

(15) In addition to the Dominion Council of Health, also at the national level there should be a permanent committee of representatives of the various health and welfare agencies and other interested parties. The functions of this



1
2
3
4 cooperative planning of goals, standards, and pro-
5 grams in order to reduce duplication and jurisdic-
6 tional differences in federal government programs;
7 coordination of national programs;
8 evaluation of programs on a regular basis.

9 (36) Coming now to the Provincial level,
10 it is recommended that each province establish a statutory
11 Advisory Health Council, comparable in membership to the
12 proposed Dominion Council of Health, to advise the
13 Minister of Health. Its functionw should include:

14 study of any proposed new health legislation or
15 proposed changes in health legislation;
16 making of recommendations to the Minister of Health
17 and any other ministers, the professions, the
18 voluntary health agencies, the universities, and to
19 any groups about any matters which affect the
20 health of the people;
21 scrutiny of any non-governmental health agencies
22 seeking provincial recognition;
23 development of close cooperative relationships
24 between government and non-government health ser-
25 vices;
26 general supervision of regional committees;
27 investigating and reporting on any reasonable pro-
28 posal for improving health services drawn to their
29 attention.
30

(37) At the Provincial level a permanent
committee representative of the official public health
services, hospital services, and the personal health
services agency should be established in each Province.

to determine the nature of goals, standards, and pro-
grams in order to secure application and financial
national objectives in the health government program;
coordination of national programs;
evaluation of progress on a regular basis.

(19) Coming now to the Provincial level,
it is recommended that each province establish a statutory
Provincial Health Council, comparable in membership to the
Provincial Health Council of Health, to advise the
Minister of Health. Its functions should include:
study of any proposed new health legislation or
proposed changes in existing legislation;
making of recommendations to the Minister of Health
and any other ministers, the professions, the
voluntary health agencies, the universities, and to
any groups or individuals which affect the
health of the province;
reporting of any non-governmental health agencies

development of close cooperative relationships
between government and non-government health ser-
vices;

general supervision of regional committees;
investigating and reporting on any responsible pro-
cesses for improving health services through their
advising;

(20) At the Provincial level, a new and
comprehensive representation of the official health
services, health services, and the personnel health
services is hereby recommended in each Province.



1
2
3
4 The functions of this committee, Provincial committee,
5 should include:

6 assuring cooperative planning of goals, standards,
7 and programs in order to reduce duplication and
8 jurisdictional conflicts in provincial government
9 programs;

10 coordinating programs to reduce unnecessary dupli-
11 cation and to promote optimal use of skilled person-
12 nel and special facilities;

13 evaluation of programs on a regular basis.

14 (38) We have already presented certain
15 recommendations to improve the public health services,
16 what we have designated as the "National Plan for Progress
17 in Public Health". We now make recommendations about
18 hospital services and personal health services.

19 (39) Hospital Commissions and similar bodies
20 should strive to develop a truly coordinated pattern of
21 hospitals on a regional basis. The pattern should include
22 large base general hospitals, medium-sized general hos-
23 pitals, such small general hospitals as may be necessary,
24 convalescent hospitals, chronic disease hospitals, mental
25 hospitals, tuberculosis sanatoria, and nursing homes.

26 Highly specialized institutes and hospitals should serve
27 several regions or even provinces in some instances.

28 (40) Further steps should be taken in each
29 province to improve the standards of hospitals not now
30 able or willing to meet accreditation standards. After
a reasonable length of time, hospitals not meeting
acceptable standards should be either removed from their
existing ownership or closed.



(41) Experimentation should be carried out in the provinces on different patterns of hospital care, such as progressive patient care and the use of specialized units.

(42) The diagnostic, laboratory, and treatment facilities of hospitals should be made available on an out-patient basis under definite supervision and rules for use by the doctors in the community.

(43) Closer supervision, controls, and a suitable pattern for financing nursing homes should be developed.

(44) To ease the problem of shortage of hospital beds, it is recommended that rehabilitation facilities and organized home care programs be extended on a regional and local basis.

(45) Forms of corporate medical practice should be encouraged by long term low interest government loans to permit the building and equipping of group practice clinics.

(46) Experimentation in methods of practice be encouraged by permitting payment for health care by salary, capitation, sessional methods, as well as by the traditional fee-for-service method.

(47) Finally, Mr. Chairman, and members of the Commission, these recommendations are made because of the great scientific and technological changes now taking place in medicine, which are altering the traditional patterns of the disease picture, medical practice, hospital care, and public health. It is our opinion that these recommendations, if implemented, will enable the Canadian health services to grow and adapt to these changes in the years ahead.



1
2 That completes the summary, sir.

3 THE CHAIRMAN: Thank you very much,
4 Dr. Rhodes. This is, as we can see from your summary
5 and from a perusal of the document itself, a very complete
6 and far-reaching report in those services which the
7 School of Hygiene concerns itself with. Dr. Firestone.

8 COMMISSIONER FIRESTONE: Dr. Rhodes,
9 as the Chairman suggested there were a lot of areas, and
10 rather than trying to cover all the things that you have
11 expounded, many of them are very much to the point and
12 don't require much questioning, I would like to concentrate
13 on one particular area and establish a little more
14 clearly what you have in mind, learn a little bit about
15 your reasoning and get a specific understanding of what
16 is involved. I would to refer, sir, if I may, to page 54,
17 your section VI, in which you deal with a proposed
18 comprehensive medical care service program for Canada.
19 You mention a suggestion in Paragraph 129 and I quote:
20 "The Government should now move into the field of personal
21 health services so as to make available to all Canadians
22 a really comprehensive health service." Do I understand
23 from those observations, sir, that you and your associates
24 are recommending a Government-operated comprehensive pre-
25 paid personal health care program?

26 DR. RHODES: Yes, sir, that is our
27 recommendation based on teaching and study and research
28 in the field.

29 COMMISSIONER FIRESTONE: Would you
30 feel such a program, if it were implemented, would meet
the widespread demands for such a program in Canada?

That is, I am the author, and I am the one who is responsible for the content of the document. I am the one who is responsible for the content of the document.

Mr. [Name], I am the one who is responsible for the content of the document. I am the one who is responsible for the content of the document. I am the one who is responsible for the content of the document.

as the [Name] suggested that there was a lot of [Name], and I am the one who is responsible for the content of the document. I am the one who is responsible for the content of the document.

on one particular area, and I am the one who is responsible for the content of the document. I am the one who is responsible for the content of the document.

already, that you have in mind, I am the one who is responsible for the content of the document. I am the one who is responsible for the content of the document.

your section of, in which you deal with a proposal. I am the one who is responsible for the content of the document. I am the one who is responsible for the content of the document.

in the [Name] about how we are into the field of personal health services so as to make available to all Canadians. I am the one who is responsible for the content of the document. I am the one who is responsible for the content of the document.

from these observations, I am the one who is responsible for the content of the document. I am the one who is responsible for the content of the document.

recommending a government-operated comprehensive pre- I am the one who is responsible for the content of the document. I am the one who is responsible for the content of the document.

that it were implemented, which I am the one who is responsible for the content of the document. I am the one who is responsible for the content of the document.



M/hm 1

Rhodes

9983

2

3

4

DR. RHODES: Certainly, sir, that is one of the objectives.

5

6

7

8

COMMISSIONER FIRESTONE: Would you say or could you perhaps explain to us when you speak of a comprehensive health service program, what do you entail in that word "comprehensive"?

9

10

11

DR. RHODES: I think perhaps I have been talking quite a lot, if I may have Dr. Hastings explain our concept of the comprehensive health services which he can do very well.

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

DR. HASTINGS: In reply to this question of our concept of comprehensiveness, it is fundamentally based on our concern that not only under voluntary prepayment but in several countries that have implemented government prepayment programs their concern had essentially been with what we call sickness insurance, the payment of doctor's bills, or, in some cases, other types of account. Our great concern, having had a chance to observe some of these things, is that there are many other facilities and services that, in our view, are an overall part of comprehensive health service. We would include in that, for instance, the promotion of mental and physical fitness, some study in this field about which, frankly, we seem to know very little; public health and preventive services where they do not now exist, diagnostic and treatment facilities, convalescent, rehabilitation, home care services and along with this research in all aspects. By this we mean not only clinical research as normally understood but operational research as well. We think



Dr. Williams: Let me say, first of all,

that one of the objects of this

meeting is to discuss the

results of the various studies that have been

conducted in the field of

the various diseases of

the human body, and I have

been talking to the effect that I have been

convinced of the importance of the

work that is being done

Dr. Williams: It is my hope that

the results of our studies of

the various diseases of the human body

will be of great value to the

various departments of the

various departments of the

various departments of the

various departments of the

various departments of the

various departments of the

various departments of the

various departments of the

various departments of the

various departments of the

various departments of the

various departments of the



Rhodes

9984

1
2
3
4 it should take into account some categories in terms
5 of training and, finally, a graduate education and so
6 forth. In other words, we feel the thing that concerns
7 us is one aspect only may be selected to the detriment
8 of a balanced overall type of approach.

9 COMMISSIONER FIRESTONE: Would you
10 include under "comprehensive" all services required to
11 deal with physical illness as well as mental illness?

12 DR. HASTINGS: Yes.

13 COMMISSIONER FIRESTONE: Or do you
14 want to put it positively to physical well-being and
15 mental well-being. I notice the emphasis you put on
16 health as a total summary of conditions.

17 DR. HASTINGS: We believe it is an
18 historical accident that man found out more about
19 physical ailments earlier than mental illness which
20 isolated the latter. We think this is unfortunate and
21 should be brought together again.

22 COMMISSIONER FIRESTONE: You mean
23 comprehensive coverage, medical care, dental care,
24 nursing care, other health personal care and pharmaceutical
25 provisions as well as hospital provisions?

26 DR. HASTINGS: Yes. In our judgment
27 it would, with this clarification, that obviously what
28 we have perhaps to do is nothing that we envisage as
29 something that is being put into effect overnight.
30 People in our profession are concerned with long term
planning and its ultimate objective and it would have
to be tempered with availability of personnel and
facilities and growth over a period of time.



at about 1900 hours in the afternoon in the
of the day, I think, I was quite satisfied and
normal. In other words, we feel the thing is all right
as it is not necessary to be subjected to the treatment
of a patient in a hospital.

Q. Now, the first thing you would
include under "psychomotor" all services regulated to
deal with physical illness as well as mental illness.

Q. Now, the first thing you would
want to put it back to physical well-being and
mental well-being. I think the explanation you give
regards as a total summary of conditions.

Q. Now, the first thing you would
historical accident that was found out about
physical illness rather than mental illness which
regarded the latter. We think this is unfortunate and
should be brought to light again.

Q. Now, the first thing you would

provide care, that health manual care and pharmacy
provisions as well as hospital provisions.

Q. Now, the first thing you would
it would, with this organization, that provisions
we have managed to do it nothing that we consider as
correcting it is all right into correct oversight.
Laws in the organization and concerned with the
patients and we will be effective and it would have
to be treated with reliability of personnel and
facilities and we will have a period of time.



Rhodes

9985

1
2
3
4 COMMISSIONER FIRESTONE: I am very
5 grateful to you for mentioning the time element in order
6 to produce a sense of perspective and reality, I take
7 it, you would expect it would take a certain period of
8 time to reach such an objective as you have outlined.
9 Would that time be five or ten years, is that the period
you are thinking of?

10 DR. RHODES: I would think certainly
11 ten years and it might well be in the neighbourhood of
12 twenty years.

13 COMMISSIONER McCUTCHEON: I think
14 Dean Ellis said 25 years this morning.

15 COMMISSIONER FIRESTONE: In certain
16 fields?

17 DR. RHODES: It could be.

18 COMMISSIONER VAN WART: Have you
19 included the therapeutics?

20 DR. HASTINGS: That is right.

21 COMMISSIONER VAN WART: Is that one
22 of the early or late?

23 DR. HASTINGS: This raises the question
24 of staging and staging to some extent, will face a
25 question of personnel and facilities and also a question
26 of other considerations. It is our view that a country
27 such as Canada could afford to put in a program of this
28 kind now provided we were prepared to spend the money
29 in these areas rather than in certain other areas where
30 we do spend it. However, if, for any reason, staging
were involved in our view it would probably run along
the lines of providing a rather more extensive service



COMMISSIONER: I am very
anxious to see for reporting the time element in order
to produce a sense of perspective and reality. I take
it you would expect it would take a certain period of
time to reach such an objective as you have outlined.
Would that time be five or ten years, is that the period?

DR. PHILLIPS: I would think certainly
ten years and it might well be in the neighborhood of
twenty years.

COMMISSIONER: I think
I am sure it will be in the neighborhood of
twenty years.

DR. PHILLIPS: It could be
twenty years. I am sure it will be in the neighborhood of
twenty years.

DR. PHILLIPS: This raises the question
of staff and of obtaining to some extent, will take a
question of personnel and facilities and also a question
of other considerations. It is our view that a company
which is going to be able to put in a program of this
kind now provided we were prepared to spend the money
in these areas rather than in certain other areas where
we do spend it. However, it, for any reason, certainly
were involved in our view it would probably run along
the lines of obtaining a more or more extensive service



Rhodes

9986

1
2
3
4 for the handicapped groups at the moment, that is those
5 handicapped by reason of age or economics, for instance.
6 Then we would move on into some of these other things
7 such as public health, preventive services, rehabilita-
8 tion, mental health service, this type of area and
9 coming finally back to the self-supporting group. If we
10 had to stage I think this would be our choice. We do
11 not think that staging is necessarily required in quite
12 that way.

13 THE CHAIRMAN: In what areas would
14 you restrict your expenditure? You say you would
15 develop from certain areas to this area?

16 DR. HASTINGS: I was not thinking of
17 present government expenditures, I was thinking of
18 personal expenditures. It seems to me a country which
19 has individual spending sums of money which it does
20 on alcohol, on tobacco and entertaining that a great
21 variety of things which will improve life of each of
22 us are nonetheless perhaps of less significance than
23 health. As people interested in health in long term
24 planning, that is our view.

25 Now, we are not saying what is
26 politically possible, that is not our decision.

27 COMMISSIONER McCUTCHEON: You may
28 have a lot of people in mental hospitals if we had to
29 make cut-backs on the fields you are talking about?

30 COMMISSIONER FIRESTONE: You say,
Dr. Rhodes, in paragraph 129 that you would like to see
such a comprehensive health care program operated by
the government. We have heard from the medical



for the handicapped, as the word is, that is those
handicapped by reason of age, or economic, for instance.
Then we would have to take some of those other things
such as public health, preventive services, rehabilitation,
then, mental health services, this type of age and
economic finally back to the self-supporting group. If we
had to start I think this would be our choice. We do
not think that aging is necessarily required in quite
that way.

THE CHAIRMAN: In what areas would
you restrict your expenditures? You say you would
draw up from certain areas to take these?

MR. HASTINGS: I was not thinking of
necessity government expenditures, I was thinking of
personal expenditures. It seems to me a country which
has individual spending sums of money which it does
on alcohol, on tobacco and entertainment that a great
variety of things which will improve life of each of
us are nonetheless subject of less allocation than
needed. As people interested in health in long term
planning, that is my view.

Now, we are not saying what is
politically possible, that is not our decision.

THE CHAIRMAN: You may
have a lot of people in mental hospitals if we had to
take cut-backs on the fields you are talking about.
CONGRESSMAN BROWN: You say,
Mr. Rhodes, in paragraph 198 that you would like to see
with a comprehensive health care program, needed by
the government. We have heard from the medical



Rhodes

9987

1
2
3
4 profession across Canada that they are very much
5 concerned if such a plan were operated by the government
6 or governments because that is what you seem to have
7 in mind. One of the objections that has been put forward
8 is that government control of the prepayment plan would
9 mean control of the medical profession and it might
10 affect the quality of medical care services. What are
11 your comments on this point?

12 DR. RHODES: We think that these fears
13 are quite groundless. We take as our example in this
14 country, the Hospital Services Commission. Particularly
15 speaking we visualize something of a personal health
16 services commission wherever possible following the
17 same guidelines that have been laid down and talked
18 about in this country for a great many years. Most of
19 these principles have been well accepted by the
20 medical profession.

21 COMMISSIONER FIRESTONE: Well, one of
22 the specific objections that were put to us was that
23 if this were, say, a provincial plan with federal
24 assistance one particular provincial government may set
25 a good budget for personal medical care services for a
26 year which budget amount might be adequate and suggestions
27 may be made by all those concerned that this budget
28 be increased for the coming year. Then the provincial
29 government would say "I am sorry, fellows, we have not
30 anymore money and you have to do the best you can with
the budget you have got". The medical profession will
then say, if this happens and the field is not permitted
to expand even if the needs are increasing or if the



Rhodes

9988

1
2
3
4 budget is cut because of economic method of diversion
5 of funds for other things, would this not affect the
6 quality and extent of medical care service provided?
7 What is your answer to this comment?

8 DR. RHODES: I expect it would if
9 there were cutting back, if there were no plans for
10 progressive improved methods. We hope that arrangement
11 would be set up so that some continued growth and
12 expansion was possible. I understand economists have
13 devised various ways of tying this to gross national
14 product and things of that kind and we understand there
15 are methods available of tying services of this sort
16 to some reasonable index of the country's growth.

17 COMMISSIONER McCUTCHEON: The only
18 difficulty is the economists cannot control the gross
19 national product.

20 DR. RHODES: Perhaps not but I think
21 they should be able to devise ways and means of ensuring
22 comprehensive health services.

23 THE CHAIRMAN: Even accepting that,
24 how do you overcome, in those circumstances, policy from
25 year to year, from one parliament to another parliament?

26 DR. RHODES: I think perhaps both of
27 us would speak to this. This is the merit of long
28 term planning as distinct from ad hoc arrangements.

29 THE CHAIRMAN: How do you nail down
30 long term spending in a democracy that one government
can undo, a government can undo today what it did
yesterday or another parliament can change things and
there is no constitutional permanency?



...in the field of economic policy of living on
of the economic system, would this not be a
qualitative and extent of a social service provided
that is more answer to this question?

...I expect it would be
there were nothing but, if there were no plan for
protection of economic interests. We hope that a government
would be set up so that some responsibility and
extension was possible. I understand economic data have
not been used in any of the field of social and
product and living of that kind, and we understand there
are a number of fields of social activities of this sort
to some reasonable limit of the economic growth.

...THE CHAIRMAN: The only
difficulty in the economic control, the gross

...perhaps not but I think
it should be able to develop and means of economic
comprehensive health services.

...THE CHAIRMAN: Even according to
how do you overcome, in those circumstances, policy from
year to year, from one parliament to another parliament
...I think the government has to

...as would be the result of law
and of course it is not a one-time thing.
...How to deal with
...in a situation of a government that has a great
...a government that has to deal with it
...in the field of economic growth and
...there is no question of economic growth



1
2
3
4 DR. HASTINGS: Perhaps I might speak
5 to this a little bit. We are not so naive as to think
6 that a government plan necessarily guarantees anything
7 any more than a private plan necessarily guarantees
8 anything.

9 THE CHAIRMAN: A change of policy?

10 DR. HASTINGS: A government plan offers
11 a framework which in our view is better than the existing
12 framework. Beyond this we believe that with the setting
13 up of these advisory councils and with the boards of
14 which they have to publish their information, to comment
15 to the public at large that it would naturally expect
16 in the event of a great national disaster be a very
17 difficult thing for a popularly elected government
18 to retreat from any policy involving the group representa-
19 tive of all the professional and other public groups
20 concerned with health. They would have great difficulty
21 doing this because they would be in democratic jeopardy
22 the next time their re-election came up.
23
24
25
26
27
28
29
30



1
2
3
4 COMMISSIONER FIRESTONE: How would you
5 achieve this independence of this mission that you are
6 talking about? After all, it would be reporting to,
7 presumably, a Minister, or would it be reporting to
8 Legislature? How would you achieve that independence?

9 DR. HASTINGS: We believe that it should,
10 first of all, be set up by Statute and guaranteed a
11 sum of money to carry it on a yearly basis. That this
12 should be built into the Act. That they should have the
13 privilege not only of reporting to the Minister, but, as
14 we have suggested, they would report to the public as
15 well on an annual basis.

16 That this would be made public know-
17 ledge, their views of things.

18 COMMISSIONER FIRESTONE: Are you pro-
19 viding funds on an annual basis that is passed in the
20 Legislature each year?

21 DR. HASTINGS: We feel this should be
22 built into the initial legislation, on a guaranteed basis,
23 sufficient so they can carry on.

24 THE CHAIRMAN: That is just the thing.
25 How do you get the guaranteed basis? Let's put our feet
26 right flat on the floor.

27 DR. HASTINGS: By passing legislation
28 in the beginning which sets up your program.

29 THE CHAIRMAN: And the legislation is
30 good until it is changed?

DR. HASTINGS: That would be correct,
but again, it would be difficult to change this without
good reason.



Mr. [Name]: How would you

believe this independence of this mission that you are
talking about? After all, it would be reporting to
presumably, a Minister, or would it be reporting to
legis. I must have would you achieve that independence?

First of all, he set up by statute and guaranteed a
sum of money to carry it on a yearly basis. That this
should be built into the Act. That they should have the
privilege not only of reporting to the Minister, but, as
we have suggested, they would report to the public as
well on an annual basis.

At this would be more public in-

formation, what kind of thing.

COMMISSIONER [Name]: And you pro-

viding funds on an annual basis that is passed in the

legislation, is each year?

Mr. [Name]: We feel this should be

the initial legislation, on a guaranteed basis,

sufficient so they can carry on.

THE CHAIRMAN: That is just the thing.

Now you get the guaranteed basis? Let's see our feet

right flat on the floor.

Mr. [Name]: By passing legislation

in the beginning which sets up your program.

THE CHAIRMAN: And the legislation is

good until it is renewed?

Mr. [Name]: That would be correct,

but again, it would be difficult to change this without

legislation.



Hastings 9991

COMMISSIONER McCUTCHEON: Dr. Hastings believes that once you break the eggs, it's very difficult to put them back into the shell again. That is the support for the view he is now expressing, I suppose.

COMMISSIONER VAN WART: In your brief at two sections you emphasize that the plans are under the jurisdiction of the Minister of Health. That makes the Minister of Health the all-powerful man in any plan.

DR. RHODES: That is the only principle we feel, sir, in a democratic country like this where Legislature has an ultimate control. We think that this is the only mechanism whereby this would work and is already working, as we point out, in two other branches of Government: Public health and hospital services.

COMMISSIONER McCUTCHEON: There is abundant evidence, surely, Dr. Rhodes, that the Public Health does not receive the financial support that even you, for example, would consider it is entitled to and certainly with the evidence before us that tendency is becoming evident for budgetary implications to affect the operation of the hospital scheme in certain Provinces, I would think looking at those two fields you would have some doubts about going further under Government auspices.

DR. RHODES: We would certainly feel, sir, that all those defects you mention are possible of correction with people sitting down together and talking it out, and that I think would be one of the great advantages of these Advisory Health Councils.

It would provide a forum which does not exist in this country at the present time for people



1951

CONFIDENTIAL - Mr. [Name]

believes that there was a great deal of work, it's very difficult to put them into the shell again. That is the situation for me, it is now expanding, I should say.

CONFIDENTIAL - Mr. [Name]

at two sections you emphasize that the plan was under the jurisdiction of the Minister of Health. That means the Minister of Health, the all-potent man in any plan.

Mr. [Name]: That is the only principle

we feel, sir, in a democratic country like this where legislation has an ultimate control. We think that this is the only mechanism whereby this would work and is already working, as we point out, in two other instances of Government: Public Health and Hospital Services.

CONFIDENTIAL - Mr. [Name]

significant evidence, namely, Mr. [Name], that the Public Health does not receive the financial support that even you, for example, would consider it is entitled to and certainly with the evidence before us that tendency is becoming evident for proprietary implications to affect the operation of the hospital scheme in certain provinces. I will think about it those two fields you would have some points about going further under Government auspices.

Mr. [Name]: It would certainly be

it, that all these factors you mention are possible of correlation with people's living down together and talking it out, and that I think would be one of the great advantages of these advisory health councils.

It would provide a forum with a dose

not exist in this country at the present time for people



Rhodes 9992

sitting down together, responsible people sitting down and talking about these major problems. Not only have we got various Government departments concerned, but other interested parties.

DR. HASTINGS: Mr. Chairman, could I just add one word to that? I would like to emphasize that we do not pretend that this brings us to the millennium that all problems are solved. We think it is an improvement over the existing situation. That is all that we pretend.

COMMISSIONER FIRESTONE: Dr. Hastings, Dr. Rhodes, your thought is if these matters are brought out into the open, into the public knowledge, that the very working of Democracy will be such that the desirable objective which you have set can be achieved?

DR. HASTINGS: Yes, sir.

COMMISSIONER FIRESTONE: It is your basic confidence in the effectiveness of the working of our democratic institutions.

DR. RHODES: It certainly is, sir. You put it very much better than we have ourselves.

COMMISSIONER FIRESTONE: When you speak of government in Paragraph 129, and then reading what you have found in subsequent forms, I take it, that you have in mind a plan that would be operated by the Provincial Government and the role of the Federal Government would be somewhat limited. You elaborate on this subsequently in Paragraph 132, etcetera.

Just to summarize it, without going into the details that you have offered us, would it be



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

1937

sitting down together, responsible people sitting down and talking about these major problems. Not only have we got various Government departments concerned, but other interested parties.

MR. HALLIDAY: Mr. Chairman, could I

just add one word to that? I would like to emphasize that we do not intend that this brings us to the realization that all problems are solved. We think it is an improvement over the existing situation. That is all that we intend.

MR. HALLIDAY: Your thought is if these matters are brought out into the open, into the public knowledge, that the very working of democracy will be such that the desirable objective which you have set can be achieved?

COMMISSIONER FIRESTONE: It is your

basic confidence in the effectiveness of the working of

MR. HALLIDAY: It certainly is, sir, for

but it very much better than we have ourselves.

COMMISSIONER FIRESTONE: When you

spoke of Government in paragraph 10, and when reading

what you have found in subsequent items, I take it, that

you have in mind a plan that would be operated by the

Executive Government and the role of the Federal Government would be somewhat limited. You elaborate on this

subsequently in paragraph 10, etcetera.

Just to summarize it, without going

into the details that you have outlined us, would it be



Rhodes 9993

your view that one of the important contributions that the Federal Government can make is in the field of planning, coordination and research and in another field, and that is the field of financial contribution to Provincially operated plans.

Are those the two major contributions the Federal Government would be expected to make?

DR. RHODES: Yes, I would say so, sir.

COMMISSIONER FIRESTONE: If we may deal a little bit with this question of financing and where the money would come from, you say in Paragraph 130 that you would recommend a scheme which would be compulsory for all residents of the Province to belong to, and then you go on, "If no other form of prepayment is permitted for the benefits provided under the Provincial plan." And that quote refers to the successful operation of such a scheme.

Now, sir, do I take it from this sentence that you have in mind a compulsory program for all residents of the Province?

DR. RHODES: I think the answer to that is similar to what we said under slightly different context. Eventually. It may well be necessary that there be some staging, and the program, if it would be used, would be used with the rider; possibly staged.

THE CHAIRMAN: You mean all the Provinces?

DR. RHODES: Oh, certainly, sir, yes. Not staging as regards some Provinces and not others. Staging by certain categories.



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

your view that one of the important contributions that
the social movement can make is in the field of
planning, consultation and research and in another field,
and that is the field of financial contribution to
providing operational plans.

And then the two major contributions
the Government would be expected to make?

MR. RICHARDS: Yes, I would say so, sir.
COMMISSIONER FIRSTON: If we may
deal a little with this question of financing and
where the money would come from, you say in paragraph
13 that you would recommend a scheme which would be
compulsory for all residents of the Province to belong to,
and that you go on, "If no other form of payment is
provided for the benefits provided under the Provincial
Plan." And that late refers to the successful operation
of such a scheme.

Now, sir, do I take it from that
sentence that you have in mind a compulsory program for
all residents of the Province?

MR. RICHARDS: I think the answer to
that is similar to what we said under slightly different
context. The answer is, it may well be necessary that there
be some staging, and the program, it is would be staged,
would be staged with the necessary staging.
MR. RICHARDS: Now when all the

not stating as regarding some provisions and not others,
staging by certain categories.



Rhodes 9994

THE CHAIRMAN: I mean to say the whole country moving forward at the same rate, whatever that rate might be?

DR. RHODES: One would certainly hope so.

THE CHAIRMAN: Is that your idea?

DR. RHODES: Yes.

DR. HASTINGS: Mr. Chairman, just to add, it could be on a similar basis to the hospital program formula devised whereby, for example, a majority of the people representing the majority of the Province, something of this type might well be devised which would be reasonably fair.

COMMISSIONER FIRESTONE: I would like to ask you, Dr. Hastings, the Hospital Insurance Plan, would you accept the principles that are presently in operation in the Ontario Hospital Insurance Plan as being principles that could be equally well applied to a personal medical care plan?

As you know now, the Hospital Insurance Plan, all wage earners through payroll deduction plans, contribute to the cost on a compulsory basis if they work in a firm of a good size. I understand about 65% of the population of Ontario is covered on that basis. Now that is a compulsory coverage, and then there are other contributors that contribute on the voluntary basis and I understand it covers about 30%, so in Ontario that covers about 95% and about 5% are not covered.

Would such a combination of compulsory wage earners working in certain firms of certain sizes, and



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

... I mean to say the
whole country is being taken at the same time, the same
... rate might be
... The would certainly hope
... Is that your idea?
... Yes.
... Chairman, just to
say, it could be on a similar basis to the hospital
... for example, a majority
of the people representing the majority of the Province,
something of this kind might well be devised which would
be reasonably fair.
... I would like
to see you, Mr. Chairman, the Hospital Insurance Plan,
would you accept the principles that are presently in
operation in the Ontario Hospital Insurance Plan as being
principles that could be equally well applied to a person
... as you know now, the Hospital Insurance
Plan, all wage earners through payroll deduction plans,
contribute to the cost on a compulsory basis if they
work in a firm of a good size. I understand about 60 per
cent of the population of Ontario is covered on that basis. The
rest is a capitalist class, and then there are other
contributions that contribute to the voluntary basis and
... so in Ontario that
... and about 3 and not covered.
... a combination of compulsory
... certain firms or certain classes, and



Hastings 9995

voluntary for the remainder, similar to what you have in Ontario under the Hospital Insurance Plan, be acceptable to you, or do you insist on compulsory 100% over a given period of time?

DR. HASTINGS: Mr. Chairman, in reply to Dr. Firestone's question, the pattern of enrolment varies from Province to Province and it would be our feeling that this should be with the Hospital Plan a matter, to some extent, for the decision of the individual Provinces.

Some of them have found a contributory system did not work in their particular situation, and I would assume if it did not work with the Hospital Insurance, it would be difficult to make it work in this area.

On the other hand, this Province has, by and large, worked on a contributory system, which seems to work and it might, therefore, decide to do this.

Now, as to the specific question of whether everyone should belong, certainly, I do not think we would object to the same system such as has been used by this Province, whereby in fact, while it is voluntary there is no other form of insurance permitted in the particular benefits that are provided.

COMMISSIONER McCUTCHEON: I want to touch on that. Why do you insist that I may not make my own provisions through another insurer?

DR. HASTINGS: We do this because we believe that this would make it financially very difficult for such a plan to operate effectively. We do not say



March 1944

...for the ... to what you have ...
...the ... the ... the ...
...you, on ... the ... over a given ...
...of time?

MR. WITNESS: Mr. Chairman, in reply,

...to Mr. Firststone's question, the pattern of enrollment ...
...varies from Province to Province and it would be our ...
...feeling that that ... with the Hospital Plan a ...
...matter to some extent, for the ... of the individual ...
...Provinces.

...some of them have ... a compulsory ...
...did not ... in a ... situation, and ...
...I would assume if it did not work with the Hospital ...
...insurance, it would be ... to make its work in this ...

...on the other hand, this Province has, ...
...worked on a compulsory system, which ...
...to ... and it might, therefore, decide to do this ...
...that, as to the specific question of ...

...whether every one should belong, certainly, I do not think ...
...the world ... to the ... system such as has been used ...
...in this ... country in fact, while it is voluntary ...
...there is no ... of insurance ... in the ...
...particular ... that are provided.

...MR. WITNESS: I want to ...
...to ... I may not take ...
...own ... through ...
...MR. WITNESS: We do this ...
...believe ... would make it ... very difficult ...
...claim to operate ...



Hastings 9996

that you must use the service.

COMMISSIONER McCUTCHEON: Oh, no, you don't me use the service. I can pay for it and not use it, but what is the financial difficulty that you envisage if I say I am not going to contribute to this plan but I am, as a choice, going to, instead of taking the risk myself, or the whole risk, I am going to insure myself or part of the risk with a commercial carrier, with anyone that I can find who will accept my money?

DR. HASTINGS: Well, first, in prefacing this I should make it very clear, as I am sure it is obvious to you, we are not economists. We do not pretend to be.

COMMISSIONER McCUTCHEON: But you said it would not work financially.

DR. HASTINGS: Our judgment is based here upon the evidence presented, for example, in the United Kingdom to the Royal Commission which studied --- this point was raised to them, the Goudenoff Commission, that point was raised and having studied that, and other things of this kind, we have come to the conclusion based on these people who are apparently knowledgeable as economists. We are basing it on people whose opinion we have to seek.

THE CHAIRMAN: You wouldn't suggest, in deference to my good friend on my right, only economists know anything about finances?

DR. HASTINGS: Well, I think in complicated matters of this kind their judgment must be heeded.

THE CHAIRMAN: Sought. Opinion sought.



Hastings 9336

that you must use the service.

COMMISSIONER MONTGOMERY: No, no, you

don't use the service. I can pay for it and not

use it, but what is the financial difficulty that you

envisage if I say I am not going to contribute to this

plan but I am, as a choice, going to, instead of taking

the risk myself, or the whole risk, I am going to insure

myself or part of the risk with a commercial carrier, with

anyone that I can find who will accept my money?

MR. HASTINGS: Well, first, in principle,

this I should make it very clear, as I am sure it is

obvious to you, we are not economists. We do not pretend

to be.

COMMISSIONER MONTGOMERY: But you said

it would not work financially.

DR. HASTINGS: Our judgment is based

here upon the evidence presented, for example, in the

United Kingdom to the Royal Commission which studied --

this point was raised to them, the Canadian Commission,

that point was raised and having studied that, and other

things of this kind, we have come to the conclusion based

on these people who are apparently knowledgeable as

economists. We are basing it on people whose opinion we

have to seek.

THE CHAIRMAN: You wouldn't suggest,

in deference to my good friend on my right, only economists

know anything about finances?

DR. HASTINGS: Well, I think in compari-

soned matters of this kind their judgment must be relied.



Hastings 9997

DR. HASTINGS: Well, perhaps it is a matter of semantics.

COMMISSIONER FIRESTONE: Do I understand, Dr. Hastings, from the explanation you have just offered us that you could anticipate, or could visualize such a plan to work, perhaps on a somewhat more flexible basis than has been explained in Paragraph 130? If I understand you correctly, and please correct me if I did not understand you adequately, that if one Province wishes to use a voluntary plan and one Province wishes to use a compulsory plan under a Federal Government scheme, both plans should be facilitated as long as they meet certain minimum requirements. Would you go that far?

DR. HASTINGS: We would, I think, go along with this concept as enunciated by you, to the extent that the Federal Government have been prepared to do it in terms of the Hospital Insurance program.

COMMISSIONER FIRESTONE: In other words, you would feel that any principles which already are in operation in the Hospital Insurance program could be equally applied, with the proper modifications, to the personal health field?

DR. HASTINGS: In general, yes.

COMMISSIONER FIRESTONE: Thank you, sir.

THE CHAIRMAN: I take it, gentlemen, you accept that it was right for the State to commandeer the facilities of all the hospitals so as to put in a Government program?

DR. HASTINGS: Well, Mr. Chairman, I would, I think with all respect, question the word

"commandeer".



WASTON: Well, perhaps it is a

very old tradition

WASTON: I understand: Do I understand

that, Dr. Waston, from the explanation you have just
given me that you are not satisfied, or could visualize
such a plan to work, perhaps on a somewhat more flexible
basis than has been explained in paragraph 100? If I
understand you correctly, and please correct me if I do

not understand you adequately, that in one Province
wishes to use a voluntary plan and one Province wishes to
use a compulsory plan under a Federal Government scheme,
both plans should be facilitated as long as they meet
certain minimum requirements. Would you go that far?
Dr. Waston: We would, I think, go

along with the concept of emanated by you, to the
extent that the Federal Government have been prepared to
act in terms of the Hospital Insurance program.

WASTON: In other
words, you would feel that any principles which already
are in operation in the Hospital Insurance program could
be easily applied, with the proper modifications, to
the general health plan?

Dr. Waston: In general, yes.

Dr. Waston: I take it, gentlemen,

you agree that it was right for the State to consider
the facilities of all the hospitals so as to put in a

Dr. Waston: Well, Dr. Chairman, I

would, I think with all respect, question the word



Hastings 9998

THE CHAIRMAN: What would you call it?

DR. HASTINGS: It was my understanding that the hospital remained under their existing ownership.

THE CHAIRMAN: I said commandeer the facilities.

DR. HASTINGS: The Board of Directors. I would not use the word "commandeer", I am afraid. It may be a difference in philosophy.

THE CHAIRMAN: I mean when you were answering, you immediately switched to ownership. My question to you is commandeering the facilities.

DR. HASTINGS: I do not feel that they have done this.

THE CHAIRMAN: All right, that is fine.

COMMISSIONER VAN WART: I understand you said that the principles of the Hospital Health and Diagnostic Plan that you were in sympathy with. Does it mean you are also in sympathy with the voluntary nature of some of those plans?

DR. HASTINGS: To the extent that they are voluntary, yes, which is a very limited voluntary extent. I think it is a reasonable one.

COMMISSIONER VAN WART: You admit they are voluntary?

DR. HASTINGS: Well, again it is a matter of a question whether it is voluntary completely or voluntary compulsory or just what it is; to the degree they are, we think it is reasonable.

COMMISSIONER FIRESTONE: In the same paragraph, 130, Dr. Rhodes and Dr. Hastings, Professor



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

Hastings 9999

THE CHAIRMAN: What would you call it?

DR. HASTINGS: It was my understanding

that the hospital remained under their existing ownership.

THE CHAIRMAN: I said commander the

DR. HASTINGS: The Board of Directors.

I would not use the word "commander", I am afraid. It

may be a difference in philosophy.

THE CHAIRMAN: I mean when you were

answering, you immediately switched to ownership. My

question to you is commanding the facilities.

DR. HASTINGS: I do not feel that they

have done this.

THE CHAIRMAN: All right, that is fine.

COMMISSIONER VAN WART: I understand

you said that the principles of the Hospital Health and

Diagnostic Plan that you were in sympathy with. Does it

mean you are also in sympathy with the voluntary nature

of some of those plans?

DR. HASTINGS: To the extent that they

are voluntary, yes, which is a very limited voluntary

extent. I think it is a reasonable one.

COMMISSIONER VAN WART: You admit they

are voluntary?

DR. HASTINGS: Well, again it is a

matter of a question whether it is voluntary completely

or voluntary compulsory or just what it is; to the degree

they are, we think it is reasonable.

COMMISSIONER FIRSTONE: In the same

paragraph, 130, Dr. Rhodes and Dr. Hastings, Professor



Hastings 9999

Brown, you speak of the payment, and I quote: "Our proposals do not exclude prepayment for additional benefits, nor do they exclude private professional practice."

Could you explain to us the first part of that sentence? "Our proposals do not exclude prepayment for additional benefits..." What additional benefits do you have in mind?

DR. HASTINGS: For example, private-duty nursing by choice, rather than medical necessity. Things of this type. In other words, things that are deemed medically necessary as comprehensive, some of these additional things as in the hospital field, private or semi-private rooms.

As to the second part, our feeling is that in a number of countries where programs are in effect, that of course, there is no compulsion on people to use the service. They are perfectly free to go to a physician if they choose to pay him directly, and are doing so in a number of these countries, to a small degree.

We do not feel that this should ever be stopped, or indeed, that one could reasonably, if one wanted to stop it.

COMMISSIONER FIRESTONE: In other words, you would feel that anyone that wanted to be covered in this national plan and still wanted to see his personal physician and wanted to pay him extra, he would be permitted to do so?

DR. HASTINGS: That would be their privilege.

COMMISSIONER McCUTCHEON: What group

...you think of the fact, and I think, "but"

...proposals do not exclude preparation for a different

...that, and do they exclude private professional practice?

...would you explain to us the first part

of that sentence? "in proposals to not exclude preparation

for additional benefits..."

...you have in mind?

Dr. EASTMAN: For example, private

data arising by choice, rather than medical necessity,

Things of this type. In other words, things that are

deemed medically necessary as comprehensive, some of these

additional things is in the hospital field, private or

As to the second part, our feeling is

that in a number of countries where programs are in

effect, that of course, there is no competition on people

to use the service. They are really free to go to

...visitation if they do not want to pay him directly, and are

...going so in a number of these countries, to a small degree

...we do not feel that this should ever

be stopped, ...that one could reasonably, if one

wanted to stop it.

...in other

...words, you would feel that anyone that wanted to be covered

...is a national plan and still wanted to see his personal

...visitation and wanted to pay him extra, he would be

...would be the end

...of, would it? That would be the

...privately.

...the fact that it is given



Hastings 10000

of the population are you really trying to protect when you make this recommendation?

DR. HASTINGS: The middle-class whom we feel, by and large, are the people having the hardest time at the present time in Canada.

COMMISSIONER McCUTCHEON: What portion of the population do you consider involved in this group that you are concerned about?

THE CHAIRMAN: You mean for these additional benefits?

COMMISSIONER McCUTCHEON: No.

DR. HASTINGS: For the whole plan?

COMMISSIONER McCUTCHEON: What is the segment of the population that you are really concerned about?

DR. HASTINGS: Probably covers about 80% of the population that we are concerned about.



Hearings

of the population are you really trying to report when

you make in a representation?

Q. A. T. I. The middle-class whom

we feel, are large, and are people having the largest

share at the present time of the

of the population to you consider involved in this kind

that you are concerned about

THE CHAIRMAN: Now ready for

additional questions

Q. A. T. I. For the whole group

COMMISSIONER NOON: What is the

percentage of the population that you are really concerned

about?

Q. A. T. I. I. Probably covers about

half of the population that we are concerned about.



Hastings

10001

COMMISSIONER FIRESTONE: The people with \$7,000 income or less?

DR. HASTINGS: Well, I don't want to set income levels. Again it depends upon how many children.

COMMISSIONER FIRESTONE: And you say also, in the last sentence, that:

"Any resident who does not wish to avail himself of benefits provided under the plan is free to pay for services privately."

What would you say of those who are in a reasonably satisfactory financial position, and prefer to pay the specialist they choose, whatever the fee may be, and they would say: "We are really paying double. First through our taxes or premium contribution, and then a second time when we choose to go to a physician of our choice"?

DR. HASTINGS: I would present two things initially. One is that this is analogous to what they are already doing in the field of public education. They are quite free to send their children to private schools if they wish to do so and secondly, in a number of countries where this type of program is in effect, that they are continuing to do this if they wish to go privately.

COMMISSIONER FIRESTONE: Thank you very much. How would this program be paid for? Where is the money going to come from to pay for it? Do you visualize a premium plan, a plan that obtains funds from taxation,



1955
Hastings

with \$7,000 income or less?

DR. HASTINGS: Well, I don't want to

set income levels. Again it depends upon how many children.

DR. HASTINGS: And you say

also, in the last sentence, that:

"any resident who does not wish to

and himself of benefits provided

under the plan is free to pay for

services privately."

That would you say of those who are in

a reasonably satisfactory financial position, and prefer

to pay the specialist they choose, whatever the fee may

be, and they would say, "We are really saying tonight,

that freedom can take on premium contribution, and

that a second time when we choose to go to a physician

on our own?

DR. HASTINGS: I would present two

things initially. One is that this is analogous to

what they are already doing in the field of public

education. They are quite free to send their children

to private schools if they wish to do so and secondly,

in a number of countries where this type of program is

in effect, that they are continuing to do this if they

wish to go privately.

DR. HASTINGS: I think you mean

much. How would this program be paid for? Where is the

money going to come from to pay for it? Do you visualize

a specific plan, a plan that certain funds from taxation,



Rhodes

10002

federal and provincial taxation? What kind of a method of payment do you envisage?

DR. RHODES: Again we would say that we are not particularly qualified to speak on this. Again we would adopt the general principles used, I think, in the hospital insurance plan, that each province is free to set any method it finds most appropriate. I don't think we have any particularly strong views.

DR. HASTINGS: There would have to be substantial federal contribution, which would presumably come out of taxation, but the provincial portion, we feel, should be left to the individual provinces.

COMMISSIONER FIRESTONE: What kind of contribution would you recommend the Federal Government should make to such a plan?

DR. RHODES: Again, without being economists, our feeling would be some kind of formula similar to that adopted for hospital insurance would be acceptable. This would require study by qualified people.

COMMISSIONER FIRESTONE: If it were of the order of 50%, similar to the hospital plan, you would consider this a significant contribution in the terms that you have used that phrase, or an equivalent phrase?

DR. RHODES: We would think this would be quite a large contribution, yes.

COMMISSIONER FIRESTONE: And is that the sort of contribution you envisage?

DR. RHODES: Yes.



Federal and provincial taxation? What kind of a method of payment do you envisage?

DR. RHODES: Again we would say that

we are not particularly qualified to speak on this. Again we would adopt the general principles used, I think, in the hospital insurance plan, that each province is free to set any method it finds most appropriate. I don't think we have any particularly strong views.

MR. HASTINGS: There would have to be

substantial federal contribution, which would presumably come out of taxation, but the provincial portion, we feel, should be left to the individual provinces.

COMMISSIONER FIRSTONE: What kind of

contribution would you recommend the Federal Government should make to such a plan?

economists, our feeling would be some kind of formula similar to that adopted for hospital insurance would be acceptable. This would require study by qualified people.

COMMISSIONER FIRSTONE: If it were

of the order of 50%, similar to the hospital plan, you would consider this a significant contribution in the terms that you have used that phrase, or an equivalent

MR. HASTINGS: We would think this would

be quite a large contribution, yes.

COMMISSIONER FIRSTONE: And is that

DR. RHODES: Yes.



Rhodes

10003

COMMISSIONER McCUTCHEON: How big a contribution do you think that might be in hundreds of millions of dollars, for the first five years?

DR. RHODES: As I say, sir, we are not attempting to convey to you that we are knowledgeable on the subject of finance, but we all feel that this country can afford it, no matter what the cost is.

COMMISSIONER FIRESTONE: And that as a result of such a plan you would expect a significant improvement over a period of time in the state of health of the Canadian nation?

DR. HASTINGS: Mr. Chairman, again no plan guarantees anything. It is partly the way in which it is designed; secondly, you will note that we have laid great stress on built-in evaluation right from the beginning. We think this is very important. Programs frequently are set up, and at the end nobody can tell whether they have had much effect or not, because there has not been this evaluation concept brought into it.

We would hope it would do this, yes.

COMMISSIONER FIRESTONE: If there is an improvement of health as a result of a more comprehensive medical care and other health care program, would that not have certain economic implications? People losing less time due to illness and therefore be more productive.

COMMISSIONER McCUTCHEON: Dr. Hastings isn't an economist. It might mean that we would have more unemployed.



Hastings

10004

COMMISSIONER FIRESTONE: You have been saying you are in favour of improving the general health status of the Canadian nation. What are some of the implications of that objective that you have stated?

DR. HASTINGS: Mr. Chairman, presumably if the experience in the past is any guide, that when you solve one problem such as we have attempted to do to a large degree of communicable disease, people live longer and you are faced with a new set of problems of diseases of old age and middle life.

COMMISSIONER McCUTCHEON: You have to provide old-age pensions.

COMMISSIONER FIRESTONE: Well, you have been both very helpful, gentlemen, and thank you very much.

COMMISSIONER McCUTCHEON: Dr. Hastings, may I take it that you are against sin, but you are not sure what it is going to cost to eradicate it?

COMMISSIONER BALTZAN: Is your proposal for comprehensive health services for Canada, as you have enunciated, a projected view of the shape of things to come, and it has been mentioned up to, say, 25 years development or do you propose immediate implementation of an all-out program?

DR. RHODES: No, I think essentially this is a long-range proposal that we feel is the ultimate goal, and we feel that the ultimate should be kept in mind right at the beginning and that in our view is the trouble with the present-day "planning for health", that it solves the ad hoc problems and does not seek new



100-100000-100000

...the ... of ... the ...
... the ... of ... the ...
... the ... of ... the ...

... the ... of ... the ...
... the ... of ... the ...
... the ... of ... the ...

... the ... of ... the ...
... the ... of ... the ...
... the ... of ... the ...

... the ... of ... the ...
... the ... of ... the ...
... the ... of ... the ...

... the ... of ... the ...
... the ... of ... the ...
... the ... of ... the ...

... the ... of ... the ...
... the ... of ... the ...
... the ... of ... the ...

... the ... of ... the ...
... the ... of ... the ...
... the ... of ... the ...



Rhodes

10005

problems, or conceive any remedy for problems already seen on the horizon.

THE CHAIRMAN: Thank you very much, gentlemen. As I said at the beginning, you have a very well-documented and complete brief here. You propose ideas that may or may not receive acceptance but you have put them forward. We know what they are and we thank you very much for having done so so clearly and lucidly.

THE SECRETARY: Mr. Chairman, before we start the next submission, if I may, the School of Hygiene, Dr. Rhodes, has filed with me a report of the Health Unit Services in Eight Provinces of Canada, 1960, which will be Exhibit No. 274A.

--- EXHIBIT NO. 274A: Report of Health Unit Services in Eight Provinces of Canada, 1960.

THE SECRETARY: And also the program for Hospital Administration, Past, Present and Future, to be known as Exhibit No. 274B.

--- EXHIBIT NO. 274B: Program for Hospital Administration, Past, Present and Future.



...for the ... for problems a really

... ..

... .. Thank you very much,

... .. As I said at the beginning, you have a very
well-documented and complete field notes. You propose
... .. may not be the same but you
... .. know what they are and we
thank you very much for having done so clearly and
... ..

... .. Mr. Gosselin, before

... .. the next session, if I may, the report of
... .. has filed with me a report of the
... .. in the provinces of Canada, 1962,
... ..

... .. of the
... .. of Canada, 1962

... .. Also the Program

... .. and
... ..

... ..
... ..



10006

THE SECRETARY: The next submission, sir, is the School of Physical and Health Education, University of Toronto, which will be Exhibit No. 275.

--- EXHIBIT NO. 275: Submission of the School of Physical and Health Education, University of Toronto.

SUBMISSION OF THE SCHOOL OF PHYSICAL
AND HEALTH EDUCATION, UNIVERSITY
OF TORONTO

Appearances: Dr. J.H. Ebbs

DR. EBBS: Mr. Chairman and members of the Commission: my submission will be even briefer than I had anticipated in the view of more recent events, which I will try to indicate as I go through this submission. I would like, first of all, however, to present the original recommendations, and refer to them further a little later.

Discussions which we have had with the professional people in the area of physical and health education have led us to make the following recommendations:

1) In order to satisfy the continuing demand for professionally trained university graduates in the field of physical and health education, entrance scholarships and bursaries should be provided to encourage more students to enter university courses in physical and health education. It is estimated that fifteen bursaries of \$500 each should be provided for women students, and ten bursaries of \$500 each for men students



Ebbs

10007

who wish to enter the School of Physical and Health Education at the University of Toronto.

2) Six bursaries for graduate training in physical and health education should be provided and the provisional sum of \$3,000 was set at that time.

3) Special grants in aid of research in physical education and in health education should be provided for at least two graduates in the School of Physical and Health Education at the University of Toronto at \$6,000 per annum each.

4) An annual budget of \$7,000 should be provided for remuneration of university staff to provide special evening and summer courses for qualified persons, such as teachers, YM, YW and YWHA and others, who wish to upgrade their qualifications in physical education and health education.

5) It is recommended that the Royal Commission on Health Services recognize the importance of physical education and health education in the total health picture of Canada, particularly the contribution which they make to good physical health and the prevention of disease through sound health education.

The need for graduates in this field, I think, is best summarized by the fact that it is estimated that in Ontario, 58% of the women and 35% of the men who are teaching physical and health education do not have university graduate qualifications in this subject. With little or no university preparation in this subject, the quality of teaching would not be at a satisfactory level. Sound health education relating



1933

7

who will be sent to the School of Physical and Health Education at the University of Toronto.

... six principles for graduate training in physical and health education should be provided and the professional staff of 15,000 was set at that time.

... physical education and health education should be provided for at least two graduates in the School of Physical and Health Education at the University of Toronto at \$4,000 per annum each.

4) An annual budget of \$7,000 should

be provided for remuneration of university staff to provide special evening and summer courses for qualified persons, such as teaching staff, YWCA and others, who wish to upgrade their qualifications in physical education and health education.

5) It is recommended that the Royal

Commission on Health Services recognize the importance of physical education and health education in the total health picture of Canada, particularly the contribution which they make to good physical health and the prevention of disease through sound health education.

It is recommended that the need for graduates in this field

... is emphasized by the fact that it is estimated that in Ontario, 10% of the women and 30% of the men who are teaching physical and health education are not having university graduate qualifications in this subject. With little or no university preparation in this subject, the quality of teaching would not be at a satisfactory level. Sound health education relating



Ebbs

10008

physical fitness to positive health is a necessary part of education. The potential influence of adequately trained teachers and leaders in this profession is undoubtedly great, and could be of increasing importance in our efforts to promote good health for all citizens of Canada.

In order to meet the very large demand for professionally trained personnel in areas related to physical education, it will be necessary to encourage more persons to enter this profession. The program recommended by the National Advisory Council on Fitness and Amateur Sport will increase the demand for qualified persons. The present acute shortage of qualified teachers in the schools will become more serious.

It is recognized that the medical profession cannot provide the amount of health education which is required. The school curriculum guarantees at least the fundamentals of good health practices. Boards of Education have recognized the values in physical education by the erection of gymnasias and swimming pools with excellent equipment in schools throughout the country. Many are still inadequate.

The need for good teachers is great. They should be well trained, dedicated persons, with equal qualifications to other members of school faculties. As university professional persons, they should have a status which is respected by education authorities, parents and students.

4. Need for Graduate Work

At the present time there are very few

Physical fitness to positive health is a necessary part of education. The potential influence of adequately trained teachers and leaders in this profession is undoubtedly great, and could be of increasing importance in our efforts to promote good health for all citizens of Canada.

In order to meet the very large demand for professionally trained personnel in areas related to physical education, it will be necessary to encourage more persons to enter this profession. The program recommended by the National Advisory Council on Fitness and Amateur Sport will increase the demand for qualified persons. The present acute shortage of qualified teachers in the schools will become more serious.

It is recognized that the medical profession cannot provide the amount of health education which is required. The school curriculum guarantees at least the fundamentals of good health practices. Boards of Education have recognized the value in physical education by the erection of gymnasiums and swimming pools with excellent equipment in schools throughout the country. Many are still inadequate.

The need for good teachers is great. They should be well trained, dedicated persons, with equal qualifications to other members of school faculties. As university professional persons, they should have a status which is respected by education authorities.

4. Need for Graduate Work

At the present time there are very few



Ebbs

10009

opportunities for graduates to continue their studies in special fields in Canada. The majority who wish higher qualifications and training must go to the United States. The expansion of facilities and undergraduate courses in Canada is producing a demand for more university teachers.

Physical and health education, like medicine, is constantly changing. Graduates of other years express regret that it is not possible to provide space and funds for presenting post-graduate courses.

5. Special Role of the University of Toronto

The School of Physical and Health Education is fortunate that it can be associated with, and obtain teaching from, many faculties, schools and departments in which the school has some related interest, such as the Faculty of Medicine, the School of Hygiene, the Connaught Laboratories, Banting and Best Institute, School of Social Work, College of Education, the Hospital for Sick Children, the Faculty of Dentistry, the School of Nursing, the Department of Household Science and Nutrition, the Institute of Child Study and the University Health Services. The University of Toronto provides excellent facilities for graduate studies.

It is hoped that the Royal Commission on Health Services will recognize the importance of physical education and health education in providing better health for the people of Canada. Physical therapy in rehabilitation is recognized. The role of physical education in prevention should also be recognized. While the National Advisory Council on Fitness and



opportunities for graduates to continue their studies in special fields in Canada. The majority who wish higher qualifications and training must go to the United States. The expansion of facilities and graduate courses in Canada is producing a demand for

physical and health education, like medicine, is constantly changing. Graduates of other years express regret that it is not possible to provide space and funds for presenting post-graduate courses.

5. Special Role of the University of Toronto

The School of Physical and Health Education

tion is fortunate that it can be associated with, and obtain teaching from, many faculties, schools and departments in which the school has some related interest, such as the Faculty of Medicine, the School of Hygiene, the Communicable Laboratories, Biting and Best Institute, School of Social Work, College of Education, the Hospital for Sick Children, the Faculty of Dentistry, the School of Nursing, the Department of Household Science and Nutrition, the Institute of Child Study and the University Health Services. The University of Toronto provides excellent facilities for graduate studies.

It is hoped that the Royal Commission

on Health Services will recognize the importance of physical education and health education in providing better health for the people of Canada. Physical therapy in rehabilitation is recognized. The role of physical education in prevention should also be recognized. While the National Advisory Council on Fitness and



ANGUS. STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Ebbs

10010

Amateur Sport will provide limited aid for bursaries and research, the special needs of the University of Toronto may not be adequately met. Present bursary funds available for undergraduate students in physical and health education average about \$10 per student enrolled. There are no graduate bursaries presently available either for study or research. Graduate courses could not be provided without at least part-time university staff.

(Reads prepared statement).



10010

10010

University staff. Courses could not be provided without at least part-time available either for study or research. Graduate schools. There are no graduate programs presently and health education average about \$15 per student funds available for undergraduate students in physical Toronto may not be adequately met. Present library and research, the special needs of the University of Western Ontario will provide limited aid for libraries



Ebbs

10011

If the Government accepts these recommendations, Mr. Chairman, it is our feeling that this will be a very good start towards the provision of what we consider to be the type of person who is needed in this field, who gives leadership. We feel the present situation of having teachers in the schools who have not had professional training such as the graduates here receive, that they cannot do an adequate job, which we feel should be done, at least by one person heading such a department in each of our schools.

We feel that such persons will have an influence on a large section of our population while they are still at school, and that if these principles are to be developed that the students who are future adults and parents, that they can contribute a very great deal to the total health picture.

THE CHAIRMAN: Thank you very much, Dr. Ebbs.

COMMISSIONER FIRESTONE: Dr. Ebbs, your recommendations are quite specific in paragraphs 1 to 4. They speak for themselves. I wonder whether you could help us a little in Recommendation 5 when you speak of the prevention of disease through sound health education? How is this achieved? What do you have in mind in this?

DR. EBBS: We have in mind here the fact that we continue to see in our hospital work children who are suffering, and adults who are suffering, from diseases which we know are preventable, and part of that, we feel, is due to the fact that the persons



1991.

1991.

in the Department of Health and
 Educational, Mr. Chairman, it is our feeling that
 this will be a very good start towards the provision
 of what we consider to be the type of person who is
 needed in this field, who gives leadership. We feel
 the present situation of having teachers in the schools
 who have not had professional training such as the
 graduates here receive, that they cannot do an adequate
 job, which we feel should be done, at least by one
 person heading such a department in each of our schools.
 We feel that such persons will have an

influence on a large section of our population in the
 they are still at school, and that if these principles
 are to be developed that the students who are forming
 habits and parents, that they can contribute a very
 great deal to the total health picture.

THE CHAIRMAN: Thank you very much.

1991.

your recommendations are quite specific in paragraphs
 1 to 4. They speak for themselves. I wonder whether
 you could help us a little in Recommendation 5 when
 you speak of the prevention of disease through sound
 health education. How is this achieved? What do you
 have in mind in that?

MR. LAM: We have in mind here the

fact that we continue to see in our hospital work
 children who are suffering, and adults who are suffering,
 from diseases which we know are preventable, and part
 of that, we feel, is due to the fact that the persons



Ebbs

10012

involved haven't had the education, adequate education, in order that they themselves could prevent such conditions, at least, at an earlier stage.

COMMISSIONER FIRESTONE: How would this health education be achieved?

DR. EBBS: Through regular health education curriculum of the schools, which now starts in the elementary schools and carries on into the secondary schools.

COMMISSIONER FIRESTONE: You appreciate, Dr. Ebbs, this is a Royal Commission to advise the Federal Government. I am trying to understand, realizing the field of education is largely, if not primarily, the provincial field; what can the Federal Government do in the field of health education?

THE CHAIRMAN: You think if they started with these recommendations that have been made, you think they will have done a lot?

DR. EBBS: I feel that this will but I think since this program which the Government has now authorized is only for a short term and since the recommendations which it now has before it will only go part way, and secondly, that it only partially, specifically refers to the universities and particularly in the field of graduate study and in research in these fields we feel that the university is a special field which cannot come into the sphere of the Council on Fitness and Amateur Sport.

COMMISSIONER FIRESTONE: That is exactly what I am wondering: how this objective which you include



12011

12011

...and hasn't had the education, adequate education,
in order that they themselves could progress and
consequently, at least, at an earlier stage.

COMMISSIONER HIRSTON: Now would

this reason education be achieved?

MR. HIRST: Through regular health

education curriculum of the schools, which now starts
in the elementary schools and carries on into the second-
ary schools.

COMMISSIONER HIRSTON: You appreciate,

Mr. Hirst, this is a Royal Commission to advise the
Federal Government. I am trying to understand, realizing
the field of education is largely, if not primarily,
the provincial field; what can the Federal Government
do in the field of health education?

THE CHAIRMAN: You think it they

started with these recommendations that have been made,
you think they will have done a lot?

MR. HIRST: I feel that this will but I

think since this program which the Government has now
authorized is only for a short term and since the
recommendations which it now has before it will only go
part way, and secondly, that it only partially, essentially
only refers to the universities and particularly in
the field of graduate study and in research in the
fields we feel that the university is a special field
which cannot come into the sphere of the Council on
Fitness and Western Sport.

MR. HIRST: That is exactly

what I am worried about: how this objective which you indicate



Ebbs

10013

1
2
3 in your Recommendation 5 could be achieved; I mean,
4 what can the Federal Government do to contribute to
5 having this objective realized?

6 DR. EBBS: Well, sir, I feel that
7 perhaps the best way would be that if the concept of
8 health education as a preventive measure and of physical
9 fitness as contributing in some way towards health, that
10 if the Dominion Government, through its existing program
11 of Dominion-Provincial public health grants for research
12 and other agencies could be expanded to more adequately
13 include this field in public health, that that would be
14 a great contribution.

15 COMMISSIONER FIRESTONE: Let me ask
16 you this specific question: would you recommend the
17 Federal Government make a federal grant to the cost of
18 health education in the schools?

19 DR. EBBS: I don't know that that is
20 necessary, not directly.

21 COMMISSIONER FIRESTONE: What could
22 the Federal Government do besides contribute to univer-
23 sity training and research? Is there anything you wish
24 them to do to achieve this objective in paragraph number
25 5?

26 DR. EBBS: To achieve the objective
27 in paragraph 5 it would be to recognize this field which
28 is contributing to health.

29 COMMISSIONER FIRESTONE: How does the
30 Federal Government recognize this?

DR. EBBS: I would think that the
opinion of this Commission might do that.

in your Recommendation 5 could be achieved; I mean, what can the Federal Government do to contribute to having this objective realized?

DR. HALL: Well, sir, I feel that

perhaps the best way would be that if the concept of health education as a preventive measure and of physical fitness as contributing in some way towards health, that if the Dominion Government, through its existing program of Dominion-Provincial public health grants for research and other agencies could be expanded to more adequately include this field in public health, that that would be a great contribution.

COMMISSIONER THOMPSON: Let me ask

you this specific question: would you recommend the Federal Government make a federal grant to the cost of health education in the schools?

DR. HALL: I don't know that that is

the Federal Government do besides contribute to university training and research? Is there anything you wish them to do to achieve this objective in particular?

DR. HALL: To achieve the objective

in Recommendation 5 it would be to recognize this field which is contributing to health.

COMMISSIONER THOMPSON: Now does the

DR. HALL: I would think that the

opinion of this Commission is that



Ebbs

10014

COMMISSIONER FIRESTONE: In other words, you are thinking of a statement of a principle rather than a complete measure to implement such a principle; is that what you are saying?

DR. EBBS: That is correct. In my original submission I would have suggested sums of money which are now probably going to be contributed; would have been recommended.

COMMISSIONER FIRESTONE: Thank you very much, sir.

THE CHAIRMAN: Thank you very much, Dr. Ebbs.



10014

Epps

COMMISSIONER FIRESTONE: In other words,

you are thinking of a statement of a principle rather than a complete measure to implement such a principle; is that what you are saying?

DR. EBBE: That is correct. In my

original submission I would have suggested some of money which are now probably going to be contributed; would have been recommended.

COMMISSIONER FIRESTONE: Thank you very

much, sir.

THE CHAIRMAN: Thank you very much, Dr.

Epps.



10015

THE SECRETARY: We will have the submission of the School of Nursing, University of Toronto, next. Miss Fidler will come forward and introduce her colleagues. The main submission will be Exhibit No. 276. Miss Fidler has also filed with me the University of Toronto School of Nursing Calendar, 1962-1963, which will be Exhibit No. 276A and another pamphlet, The Experiences of Eight Cardiac Patients During a Period of Hospitalization in a General Hospital. That will be known as Exhibit 276B.

--- EXHIBIT NO. 276: Submission of the School of Nursing, University of Toronto.

--- EXHIBIT NO. 276A: University of Toronto School of Nursing Calendar, 1962-1963.

--- EXHIBIT NO. 276B: The Experiences of Eight Cardiac Patients During a Period of Hospitalization in a General Hospital.

THE CHAIRMAN: We will have a short recess.

--- Short Recess

SUBMISSION OF THE SCHOOL OF NURSING,
UNIVERSITY OF TORONTO.

Appearances: Miss N.D. Fidler
Miss H.M. Carpenter
Miss M.J. Wilson
Miss M.K. King

MISS FIDLER: Mr. Chairman, may I introduce my colleagues on whom I would like to call? On my right is Miss Carpenter and on my left, Miss King



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

THE SECRETARY: We will have the submission of the School of Nursing, University of Toronto, next. Miss Fisher will come forward and introduce her colleagues. The main submission will be Exhibit No. 276. Miss Fisher has also filed with me the University of Toronto School of Nursing Calendar, 1962-1963, which will be Exhibit No. 276A and another pamphlet, The Experiences of Eight Cardiac Patients During a Period of Hospitalization in a General Hospital. That will be known as Exhibit 276B.

- EXHIBIT NO. 276: Submission of the School of Nursing, University of Toronto.
- EXHIBIT NO. 276A: University of Toronto School of Nursing Calendar, 1962-1963.
- EXHIBIT NO. 276B: The Experiences of Eight Cardiac Patients During a Period of Hospitalization in a General Hospital.

THE CHAIRMAN: We will have a short

--- Short recess

SUBMISSION OF THE SCHOOL OF NURSING,
UNIVERSITY OF TORONTO.

Miss H.M. Carpenter
Miss M.J. Wilson

MISS FISHER: Mr. Chairman, may I introduce my colleagues on whom I would like to call? On my right is Miss Carpenter and on my left, Miss King



Fidler

10016

and Miss Wilson. May I read our introduction, which is brief, and our recommendations?

THE CHAIRMAN: May I invite you to have a chair?

MISS FIDLER: The introduction concerns the School of Nursing at the University of Toronto.

1. Commencing in 1920 with a one-year certificate course in Public Health Nursing for graduates of hospital schools of nursing, the School of Nursing now assumes responsibility for the preparation of nurses to give care to the sick and to act as health teachers to patients and families, and for the preparation of nursing personnel, for teaching and administrative positions to make such services possible. (Tables 1 and 2)

2. The following programs are offered:

(1) Two courses leading to the degree of Bachelor of Science in Nursing:

a) A four-year program for students coming directly from high school.

This course prepares students to become registered nurses and qualifies them for practice in both the hospital and the public health field;

b) A three-year program for graduates of diploma schools of nursing. This course offers special study in a selected field of nursing (nursing education, nursing administration, public health nursing) as well as studies in the humanities and sciences.



1955 Professor

and Miss Wilson. May I read our introduction, which is brief, and our recommendations?

THE CHAIRMAN: May I invite you to have

MISS TIDDER: The introduction concerns

the School of Nursing at the University of Toronto.

1. Commencing in 1955 with a one-year

certificate course in Public Health Nursing for graduates

of hospital schools of nursing, the School of Nursing

now assumes responsibility for the preparation of nurses

to give care to the sick and to act as health teachers

to patients and families, and for the preparation of

nursing personnel, for teaching and administrative posi-

tions to make such services possible. (Tables 1 and 2)

2. The following programs are offered:

(1) Two courses leading to the degree

of Bachelor of Science in Nursing:

a) A four-year program for students

coming directly from high school.

This course prepares students to become

registered nurses and qualifies them

for practice in both the hospital and

the public health field;

b) A three-year program for graduates

of diploma schools of nursing. This

course offers special study in a

selected field of nursing (nursing

education, nursing administration,

public health nursing) as well as studies

in the humanities and sciences.



Fidler

10017

(2) Certificate courses of one academic year in Public Health Nursing, Public Health Nursing: Advanced, Nursing Education and Hospital Nursing Service for graduate nurses.

(3) Refresher and Extension courses.

3. The philosophy of the School underlies all its curricula and expresses the belief that the humanities and sciences are integral parts of education for professional nursing. On this basis, courses dealing with the scientific principles underlying nursing, with the social, physical and biological sciences, and with the humanities are arranged concurrently to provide the opportunity for integration and reinforcement of one through the other. To facilitate such integration and reinforcement and to protect the educational experience of the student, nursing courses, including practice in hospital and other community agencies are arranged and taught by the faculty of the School itself.

4. Canadian graduates of the School have been successful in their fields, and have held or hold such positions as Chief Nursing Consultant to the Department of National Health and Welfare, Director-in-Chief of the Victorian Order of Nurses and Directors of Victorian Order of Nurses' branches, Director and Assistant Director of Public Health Nursing, Toronto, and of other Departments of Public Health Nursing; consultants on public health nursing staffs, teachers in university and hospital schools of nursing, and with the World Health Organization. An increasing number are interested in the



(2) Certificate course of one academic

year in Public Health Nursing, Public Health Nursing:
Advanced, Nursing Education and Hospital Nursing Service
for graduate nurses.

(3) Refresher and Extension courses.

lies all its curricula and expresses the belief that
the humanities and sciences are integral parts of educa-
tion for professional nursing. On this basis, courses
dealing with the scientific principles underlying
nursing, with the social, physical and biological
sciences, and with the humanities are arranged concurrently
to provide the opportunity for integration and reinforce-
ment of one through the other. To facilitate such
integration and reinforcement and to protect the educa-
tional experience of the student, nursing courses, inclu-
ding practice in hospital and other community agencies
are arranged and taught by the faculty of the School

4. Canadian graduates of the School

have been successful in their fields, and have held or
hold such positions as Chief Nursing Consultant to the
Department of National Health and Welfare, Director-in-
Chief of the Victorian Order of Nurses and Directors of
Victorian Order of Nurses' branches, Director and Asso-
ciate Director of Public Health Nursing, Toronto, and of
other Departments of Public Health Nursing; consultants
on public health nursing staffs, teachers in university
and hospital schools of nursing, and with the world health
organization. An increasing number are interested in the



Fidler

10018

direct nursing of patients, but there is a tendency to persuade them to go into teaching or supervision.

5. From its inception, the School has had international students from many countries, usually sponsored by such organizations as the Rockefeller Foundation, the Colombo Plan and the World Health Organization, and the International Red Cross. Many of these graduates hold important positions and are leaders of nursing in their own countries or in the World Health Organization.

The following are our recommendations:

1. That comprehensive health services should be made available to all people, including those who are not financially able to provide for themselves.
(Page 5, paragraphs 6 - 8)

2. That greater emphasis be placed on preventive and rehabilitative aspects of health services.
(Page 6, paragraph 9)

3. That a Provincial Advisory Committee on health services be established in each province.
(Page 6, paragraph 10)

4. That there be mandatory legislation for the licensing of nurses. (Page 7, paragraphs 11 - 13)

5. That there should be two groups of nurses (Pages 8 - 13, paragraphs 14 - 30):

a) graduates of university programs in which the content of the humanities and sciences is integrated with nursing and in which the university assumes responsibility for the total program



direct nursing of patients, but there is a tendency to
persuade them to go into teaching or supervision.

and international students from many countries, usually
sponsored by such organizations as the Rockefeller
Foundation, the Coleridge Plan and the World Health Organization.

Graduates hold important positions and are leaders of
nursing in their own countries or in the World Health

The following are our recommendations:

1. That comprehensive health services
should be made available to all people, including those
who are not financially able to provide for themselves.
(Page 1, paragraphs 6 - 8)

2. That greater emphasis be placed on
preventive and rehabilitative aspects of health services.
(Page 6, paragraph 9)

3. That a Provincial Advisory Committee
on health services be established in each province.
(Page 6, paragraph 10)

4. That there be mandatory legislation
for the licensing of nurses. (Page 7, paragraphs 11 - 13)

5. That there should be two grades of
nurses (Pages 8 - 12, paragraphs 14 - 20):

a) Graduates of university programs
in which the content of the curriculum
and sciences is integrated with nursing
and in which the university assumes
responsibility for the total program



Fidler

10019

including the teaching and practice of nursing. The graduates of these programs should be qualified for the practice of both hospital and public health nursing;

b) graduates of a new type of program within the structure of the educational system. The exact place for this institution and its grade placement should be determined by investigation.

6. That graduate programs in nursing should be developed in Canadian universities. (Pages 13 - 16, paragraphs 31 - 39)

7. That in order to improve the practice of nursing, research areas in nursing care should be established in selected and controlled situations. (Pages 16 - 17, paragraphs 40 - 42)

8. That scholarships, bursaries and loans should be made available where necessary for students of both groups defined in recommendation 5 and for graduate study. (Pages 17 - 19, paragraphs 43 - 49)

THE CHAIRMAN: Thank you, Miss Fidler. Is it implicit in your 5(b) on page 1 of the recommendations that that school, whenever it may come in the future - we know you are not speaking of today - when that school comes that it will not be a hospital school?

MISS FIDLER: No, Mr. Chairman, we haven't thought that was part of education.

THE CHAIRMAN: Your thinking has not gone that far?



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

including the teaching and practice
of nursing. The graduates of these
programs should be qualified for the
practice of both hospital and public
health nursing;

6) Graduates of a new type of program
within the structure of the educational
system. The exact place for this
institution and its grade placement
should be determined by investigation.

8. That graduate programs in nursing
should be developed in Canadian universities. (Pages
18 - 19, paragraphs 31 - 33)

7. That in order to improve the
practice of nursing, research areas in nursing care
should be established in selected and controlled situa-
tions. (Pages 18 - 19, paragraphs 40 - 42)

8. That scholarships, bursaries and
loans should be made available where necessary for
students of both groups defined in recommendation 5 and
for graduate study. (Pages 17 - 19, paragraphs 43 - 45)

THE CHAIRMAN: Thank you, Miss Fidler.

It is implicit in your 5(d) on page 1 of the recommenda-
tions that that school, whenever it may come to the
fore - we know you are not speaking of today - when
that school comes that it will not be a hospital school?

MISS FIDLER: Yes, Mr. Chairman, we
haven't thought that was part of education.

THE CHAIRMAN: Your thinking has not
come that far?



Fidler

10020

MISS FIDLER: It wouldn't be in the hospital, no. Within the educational system, we mean the system of general education.

THE CHAIRMAN: Therefore not in the hospital?

MISS FIDLER: Eventually no, not in the hospital.

THE CHAIRMAN: When it comes?

MISS FIDLER: Yes.

THE CHAIRMAN: In that setting in the future, whenever it may come, what do you see this new type of nurse doing?

MISS FIDLER: Well, we see her as a fusion of the existing registered nurse, diploma nurse, and the present nursing assistant; really becoming the type of nurse which, for instance, the Nightingale School of Nursing is trying to produce. She would be capable of giving very competent care in most situations but under the supervision of a university graduate who would be available where exceptional judgment or skill was required.



MISS FIDLER: It wouldn't be in the hospital, no. Within the educational system, we mean the system of general education.

THE CHAIRMAN: Therefore not in the

hospital?

MISS FIDLER: Eventually no, not in

the hospital.

THE CHAIRMAN: When it comes?

MISS FIDLER: Yes.

THE CHAIRMAN: In that setting in the

future, whenever it may come, what do you see this new type of nurse doing?

MISS FIDLER: Well, we see her as a

fusion of the existing registered nurse, diploma nurse, and the present nursing assistant; really becoming the type of nurse which, for instance, the Nightingale School of Nursing is trying to produce. She would be capable of giving very competent care in most situations but under the supervision of a university graduate who would be available where exceptional judgment or skill was required.



1/hm

Fidler

10021

1
2
3
4 THE CHAIRMAN: Do you see her as,
5 by and large, taking place of the diploma nurse today?

6 MISS FIDLER: Yes, and absorbing
7 the nursing assistant.

8 COMMISSIONER GIRARD: Mr. Chairman,
9 Miss Fidler: Mr. Chairman, if you would allow I would
10 like to elaborate little bit more on recommendation 5(b)
11 that you have just spoken about. I believe there is
12 little difference in this brief regarding the way of
13 approaching this recommendation. In other briefs it
14 was stated but in this brief there is something more
15 as it should be. The School of Nursing of Toronto
16 University is conscious of the fact we need more research
17 in nursing and I believe your idea is to approach this
18 problem by a research study; is that right? You say
19 somewhere here that you would like to do some research
20 on the place of this second type and where you would
21 like this second type nurse to get her education.

22 MISS FIDLER: We think it requires
23 an investigation and I think we have discussed -- we
24 name a number of possible places to be investigated. We
25 do not know whether we are going to have junior colleges,
26 we do not know too much about the new high school
27 program and I think we would feel that we would like to
28 see a pilot project in a technological college such as
29 Ryerson Institute.

30 COMMISSIONER GIRARD: Now, Miss Fidler,
would you or your school be ready to undertake a pilot
project because we understand it is needed very much.
We are all talking about this second nurse and that she



THE CHAIRMAN: Do you see her as,

by and large, taking place of the diploma nurse today?

MISS FIDLER: Yes, and absorbing

COMMISSIONER GIRARD: Mr. Chairman,

Miss Fidler: Mr. Chairman, if you would allow I would

like to elaborate little bit more on recommendation 8(b)

that you have just spoken about. I believe there is

little difference in this brief regarding the way of

approaching this recommendation. In other words it

was stated but in this brief there is something more

as it should be. The School of Nursing of Toronto

University is conscious of the fact we need more research

in nursing and I believe your idea is to approach this

problem by a research study; is that right? You say

someone here that you would like to do some research

on the place of this second type and where you would

like this second type nurse to get her education.

MISS FIDLER: To think it requires

an investigation and I think we have discussed -- we

name a number of possible places to be investigated. We

do not know whether we are going to have junior colleges,

we do not know too much about the new high school

program and I think we would feel that we would like to

see a pilot project in a technological college such as

would you or your school be ready to undertake a pilot

project because we understand it is needed very much.

We are all talking about this second nurse and that she



Fidler

10022

1
2
3
4 should be placed here and there and I think we agree
5 with you that we should have some research on it.
6 However, who is to do this research? Would the School
7 of Nursing of the University of Toronto be ready to
8 undertake such a pilot project or should it be done
9 by a school of nursing? Should it be done by the
10 National Association? What is your opinion on this?

11 MISS FIDLER: Obviously the school
12 concerned, the technological college would have to have
13 a part in this. I think we could go so far as to say
14 we would be glad to try a formula, a plan, and see if
15 there is any possibility of such a project being
16 established in this institution and if there does appear
17 to be we would hope very much that the school could
18 undertake to collaborate in that piece of research.

19 COMMISSIONER GIRARD: What different
20 phases do you see in this project and how would you
21 go about it? Would you need more funds and where would
22 they come from? This is a lot of questions, I realize,
23 but I think it is most important that this piece of
24 research be done and I can see no better place to have
25 it done or under no better auspices.

26 MISS FIDLER: Financial help would
27 be needed, I do not think perhaps to any very great
28 extent. The technological college would have to set
29 up a new course, we would have to find out what they
30 thought that would entail and we would need one or two
nurses to work with that group. Exactly what the
application for this project would be, what it would
amount to I am afraid we do not know at the moment. I
think we can say we would be very glad to try and get

should be placed here and there and I think we agree

with you that we should have some research on it.

However, who is to do this research? Would the school

of Nursing at the University of Toronto be ready to

undertake such a pilot project or should it be done

by a school of nursing? Should it be done by the

National Association? What is your opinion on this?

MISS TIBBET: Obviously the school

concerned, the technological college would have to have

a part in this. I think we could go so far as to say

we would be glad to try a formula, a plan, and see if

there is any possibility of such a project being

established in this institution and if there does appear

to be we would have very much that the school could

undertake to collaborate in that piece of research.

COMMISSIONER CLARK: What different

classes do you see in this project and how would you

go about it? Would you need more funds and where would

they come from? This is a lot of questions, I realize,

but I think it is most important that this piece of

research be done and I can see no better place to have

it done or under no better auspices.

MISS TIBBET: Financial help would

be needed, I do not think perhaps to any very great

extent. The technological college would have to set

up a new course, we would have to find out what they

thought that would entail and we would need one or two

people to work with that group. Excuse me, what the

application for this project would be, what it would

amount to I am afraid we do not know at the moment. I

think we can say we would be very glad to try and get



Fidler

10023

1
2
3
4 this information and forward it to the Commission.

5 COMMISSIONER GIRARD: Would you do
6 that, Miss Fidler? Would you be prepared, you and your
7 staff be prepared to work out a plan for such a research
8 project and send it to the Commission?

9 MISS FIDLER: Yes.

10 THE CHAIRMAN: May we enquire what
11 research project are you now talking of? Are you talking
12 of where this new school might be established, accepting
13 that there must be a new school, or is your project
14 initially (a) is the idea itself sound and, if so, where
15 would it be carried out? What is your research? Is
16 it going to start half-way down accepting the idea that
17 the nursing school and the hospital is an out-dated,
18 out-moded system and we must go someplace else?

19 MISS FIDLER: I think you must admit
20 there is a pretty general feeling among nurses that it
21 was not producing all the results that we hoped for.

22 THE CHAIRMAN: And the medical schools
23 are not producing the results, the school hygienists tell
24 us they are not doing nearly as well as they thought
25 they would.

26 MISS FIDLER: Of course, nobody
27 produces perfect results.

28 THE CHAIRMAN: Nobody should be
29 abandoned?

30 MISS FIDLER: It is a very unusual
way of educating professional students.

THE CHAIRMAN: I am talking about doing
your research study, and all I am saying is, where were



10003
Fidler

this information and forward it to the Commission.

COMMISSIONER (Fidler): Would you do

that, Miss Fidler? Would you be prepared, you and your staff be prepared to work out a plan for such a research

project and send it to the Commission?

MISS FIDLER: Yes.

THE CHAIRMAN: May we enquire what

research project are you now talking of? Are you talking of where this new school might be established, accepting

that there must be a new school, or is your project

initially (a) is the idea itself sound and, if so, where

would it be carried out? What is your research? Is

it going to start half-way down accepting the idea that

the nursing school and the hospital is an out-dated,

out-moded system and we must go someplace else?

MISS FIDLER: I think you must admit

there is a pretty general feeling among nurses that it

was not producing all the results that we hoped for.

THE CHAIRMAN: And the medical schools

are not producing the results, the school hygienists tell

us they are not doing nearly as well as they thought

they would.

MISS FIDLER: Of course, nobody

produces perfect results.

THE CHAIRMAN: Nobody should be

abandoned.

MISS FIDLER: It is a very unusual

way of educating professional students.

THE CHAIRMAN: I am talking about doing

your research study, and all I am saying is, where were



Fidler

10024

1
2
3 you starting from, are you starting from the philosophical
4 concept of where the school should be or do you accept
5 that as something decided by somebody and only as to
6 where the new school should be located?

7 MISS FIDLER: As to where a new school
8 could be located.

9 THE CHAIRMAN: You had made up your
10 minds on the other phase of it, you do not want research
11 on it?

12 MISS FIDLER: I am sorry, may we have
13 the question again.

14 THE CHAIRMAN: You do not want research
15 on whether the nursing school should continue to be in
16 the hospital milieu?

17 MISS FIDLER: We have had some
18 experiments ---

19 THE CHAIRMAN: Have you come to form
20 an opinion? It is immaterial in this sense what your
21 opinion is, it is either one or the other or you
22 have not one.

23 MISS FIDLER: Whether it should or
24 should not be?

25 THE CHAIRMAN: Yes.

26 MISS FIDLER: I believe it should not
27 be.

28 THE CHAIRMAN: Therefore, the only
29 research you want to do is as to where it should be?

30 MISS FIDLER: Yes. I wonder if I
might ask Miss Carpenter to comment.

MISS CARPENTER: I think the only



Fidler

10025

1
2
3 additional thing is, I think we do feel for many reasons
4 that the school should be outside the hospital. I
5 think we realize that we must do research, we must find
6 out where it should be. I do not think that we have a
7 quick answer as to where it should be but I think it
8 has been shown on the study. The only experiment that
9 has been done was directed by Miss Fidler in the
10 Metropolitan School in Windsor and it was shown there
11 could be greater economy of time and money by educating
12 the student as a student for two years and having their
13 program completed as soon as possible. The nursing
14 profession have been looking for ways of carrying on a
15 kind of nursing education that would be economical in
16 time and money and in the use of facilities already in
17 the community, the teaching staff and other groups may
also contribute to nursing education.

18 COMMISSIONER GIRARD: I think that
19 is all we can say on this subject for now. In your
20 recommendation number 4 you say:

21 "That there be mandatory legislation
22 "for the licensing of nurses."

23 Does the event of the new Act and the
24 College of Nursing bring any change in this recommenda-
tion of yours or does this recommendation still stand?

25 COMMISSIONER McCUTCHEON: The Act
26 proclaimed, the recommendation is accomplished.

27 MISS FIDLER: I think the Act does
28 not.

29 THE CHAIRMAN: Do you think the Act
30 is inadequate? That is what I thought we heard the other



additional thing is, I think we do feel for many reasons
 that the school should be outside the hospital. I
 think we realize that we must do research, we must find
 out where it should be. I do not think that we have a
 final answer as to where it should be but I think it
 has been shown on the study. The only experiment that
 has been done was directed by Miss Fisher in the
 Metropolitan School in Winston and it was shown there
 could be a greater economy of time and money by educating
 the student as a student for two years and having their
 program continued as soon as possible. The nursing
 profession have been looking for ways of carrying on a
 kind of nursing education that would be economical in
 time and money and in the use of facilities already in
 the community, the teaching staff and other groups may
 also contribute to nursing education.
 COMMISSIONER CLARK: I think that
 as all we can say on this subject for now. In your
 recommendation number 5 you say:
 "That there be mandatory legislation
 for the licensing of nurses."
 Was the intent of the new Act and the
 change of Virginia when any change in this recommenda-
 tion or your own does this recommendation still stands?
 Yes, the recommendation is accomplished.
 COMMISSIONER CLARK: I think the new does
 not.
 COMMISSIONER CLARK: Do you think the Act
 is inadequate? What is what I thought we found it.



Fidler

10026

1
2
3 day.

4 MISS FIDLER: This was written before
5 we had seen the Act. The request was that it should
6 include licensing and it does not. Frankly, I think we
7 must say we are not too hopeful of seeing this
8 immediately either but we think it is important for the
9 safety of patients.

10 COMMISSIONER GIRARD: Have you anything
11 to add, Miss Carpenter?

12 MISS CARPENTER: No, I think it is
13 well stated, certainly as long as people who have
14 partial training can nurse for hire the patient does
15 not know what quality of preparation they have and it
16 is not safe in terms of patient care.

17 COMMISSIONER GIRARD: There is not
18 anything we can do for the moment?

19 MISS CARPENTER: No.

20 COMMISSIONER GIRARD: As I stated a
21 while ago, I think the School of Nursing of the Toronto
22 University is research conscious and we have an example
23 here of some of the research that has been done in the
24 School in Appendix B, the experience of eight cardiac
25 patients in general hospital and in your recommendation
26 there you say:

27 "That in order to improve the practice
28 "of nursing, research areas in nursing
29 "care should be established in selected
30 "and controlled situations".

Would you care to expand further what
kind of research and how you would like to implement this



1955

1955

1955

... This was written before
 ... The request was that it should
 ... and this is what I think we
 ... we are not too happy in seeing this
 ... we think it is important for the
 ... as a way of patient.

... Have you anything
 ... I think it is

... well stated, certainly as long as people who have
 ... partial training can make for some the patient does
 ... not know what dialysis of preparation they have and it
 ... is not safe in terms of patient care.

... There is not
 ... anything to be done for the moment?
 ... No.

... As I stated a
 ... I think the School of Medicine of the Toronto
 ... is really in need of research and we have an example
 ... of some of the research that has been done in the
 ... School in England, the experience of eight or nine
 ... in general hospital and in your recommendation
 ... there you see

... in order to improve the practice
 ... research areas in training
 ... should be established in selected
 ... controlled situation.
 ... to expand further work
 ... you would like to discuss this



Fidler

10027

1
2
3 recommendation?

4 MISS FIDLER: To begin with, I would
5 like to ask Miss King who has thought a good deal about
6 this recommendation if she would speak to it.

7 MISS KING: Mr. Chairman, what we
8 want to do and how we think it ought to be implemented?

9 COMMISSIONER GIRARD: Yes, and why
10 we want some research along this line and particularly
11 why?

12 MISS KING: I think to start off with,
13 we have had research projects carried out in Canada
14 largely in the field of nursing education with some
15 projects in nursing administration, service administra-
16 tion. We as a school feel it is most important that we
17 have direct research into patient care, the nursing
18 care of patients and this is the basis, I believe, for
19 this recommendation.

20 Now, in order to research into nursing
21 care of patients we feel it is very necessary to carry
22 this through as any recognized piece of research would
23 be carried through, in a controlled situation where the
24 group doing the research has some control of the
25 situation that the research is being done in. We would
26 see this being done in units set aside for research
27 in nursing care in the first instance a general hospital
28 and with this service institution collaborating with
29 the University School of Nursing in the actual research
30 that would be undertaken.

COMMISSIONER GIRARD: Would this
piece of research tie up with the work that the Canadian



Fidler

10028

1
2
3 Nursing Association is doing along the line of nursing
4 services in the hospital, the investigation, or would
5 it be a part of it?

6 MISS KING: I think the one could
7 complement the other very nicely. I do not think they
8 are the same at all. I understand that the Canadian
9 Nurses Association is doing a study into nursing service
10 criteria of nursing care and I believe this could
11 complement what they are doing but certainly not
12 overlapping insofar as we are interested in pieces of
13 work, a specific nursing care, bedside care.

14 -

18 -

24 -

29 -



R/hm 1

King

10029

2

3

4

5

6

7

THE CHAIRMAN: I wonder if we could anchor this to something practical, find out what you are talking about. Is this the type of thing that we heard about where nurses are doing part of the things that the doctors should be doing?

8

MISS KING: Mr. Chairman I ---

9

10

11

12

13

14

THE CHAIRMAN: And they are being asked to undertake duties which have been, up to now, medical functions, medical duties but which are being taken over by the nursing profession by degrees and perhaps for the future, to a greater extent. Now is this the kind of situation that you think should be looked into pretty carefully?

15

16

17

MISS KING: May I answer it in two parts. I think possibly the answer, or the question that you are asking may be one of the results of it.

18

19

20

21

22

23

24

25

Just for a case at hand, let us say that there was some possible continuation of the study, or the piece of work that Miss Alamand has done in the experience of eight cardio patients during a hospital stay. Now Miss Alamand suggests that there are many needs of patients here by the nursing staff. There are several areas where there are many of these. We could take, for instance, the elderly patient confused who may be admitted to a hospital ward.

26

27

28

29

30

I think that this is one instance that we very much need research in the nursing care. How does the nurse most effectively work with this patient? What situation and environment in the ward make this person more confused? This type of thing or how is the nurse to work most effectively say with a child with

Q. Now, I wonder if we could

change this to something more practical, and what you

are talking about. Is this the type of thing that

we find about where nurses are doing part of the thing

that you are talking about, is that right?

A. Yes, that is right.

Q. Now, I wonder if you are being

asked to do some of the things which have been, or are now,

medical, nursing, and other things which are being

taken over by the nursing profession by doctors and

others, for the future, to a greater extent, is that

this the kind of situation that you think should be

Q. Now, I wonder if you are being

asked, I think possibly the answer, on the question

that you are asking me one of the results of it,

that for a case at hand, let me say

that there are a few possible continuation of the study,

on the line of work that Miss Alford has done in

the experience of eight cardiac patients coming to

hospital stay. Now Miss Alford suggests that there

are many needs of patients here for the nursing staff,

there are some at present where there are many of these,

as could be, for instance, the elderly patients

contacted who may be admitted to a hospital ward.

I think that there is one further thing

we very much need attention in the nursing care. You

know the nurse most often is very busy with the patients

and attention and attention in the ward where there

is a great many things. This is one of the things that you

are going to work most effectively say with a child with



King

10030

1
2
3
4 a hare lip or cleft palate in helping that child,
5 helping the family adjust and give the best care. I
6 think these are details. Now doing a research project
7 on this, you could very easily see where the function --
8 or clarifying the function of the nurse which we need
9 if we are going to have good comprehensive service. I
10 think it would in part clarify the function of the nurse.
11 I think this is primarily an investigation into nursing
12 care of specific patients.

13 COMMISSIONER VAN WART: You visualize
14 training by university trained nurses. You visualize
15 diploma trained nurses, taking the nursing training
16 away from the hospitals, and we have nursing assistants
17 who are trained outside of the hospital also, and who,
18 it was brought out yesterday, was 20% of the nursing.

19 From the hospital's point of view
20 who is going to co-ordinate all these three segments
21 when they start nursing in the hospital? Who is going
22 to be the supreme commander and dictator, and so on,
23 et cetera, to carry out the system?

24 THE CHAIRMAN: You'll find a boss
25 someplace.

26 MISS FIDLER: Well they are trying
27 to co-ordinate three of them now in the hospital, and
28 with a good deal of difficulty. Do you mean when they
29 are actually in the hospital who will co-ordinate?

30 COMMISSIONER VAN WART: Actually
working in the hospital, what is the organization to
be?

MISS FIDLER: The nursing staff of the



Fidler

10031

hospital.

COMMISSIONER VAN WART: Are they under control of the Board of Administration of the hospital or what is going to be the -- how are they going to work? How is the thing going to be carried out when you get these groups of graduates coming.

MISS FIDLER: They would be definitely under the control of the Board of Administration.

THE CHAIRMAN: In the picture that Dr. Van Wart has illustrated is there any difference from the many hospitals we have today where there are no student nurses, no student nurses at all? The whole staff is graduate nurses of some kind?

COMMISSIONER VAN WART: It was brought out here the nursing assistants have created an organization of their own independent of the registered nurses' organization which has been recognized on the Board in the new Act. Now, you have created another group of nurses, diploma nurses, which is the nurse at present being trained in the hospital.

You are taking her out of the hospital and training her outside. Now she is going to come back to work in the hospital. You have three groups trained in separate institutions carrying out the nursing service in the hospital.

Now what is the co-ordination?

MISS FIDLER: That is what we have now Doctor. Three separately trained, and certainly the period of adjustment will be complicated. Whether it is more complicated than it is now ---



COMMISSIONER VAN WART: Are they under

control of the board of administration of the hospital
or what is going to be the -- how are they going to
work? How is the time going to be carried out when
you get these groups of graduated coming.

THE CHAIRMAN: They would be definitely

under the control of the Board of Administration.

THE CHAIRMAN: In the picture that

Mr. Van Wart has illustrated is there any difference from
the army hospital as we have today where there are no
nurses, no staff of nurses at all? The whole
staff is graduate nurses of some kind?

COMMISSIONER VAN WART: It was brought

out here the nursing assistants have created an
organization of their own independent of the registered
nurses' organization which has been recognized on the
board in the new Act. Now, you have created another
group of nurses, diploma nurses, which is the nurse
at present being trained in the hospital.

You are taking her out of the hospital

and training her outside. Now she is going to come
back to work in the hospital. You have three groups
trained in separate institutions carrying out the
nursing service in the hospital.

Now what is the co-ordination?

THE CHAIRMAN: That is what we have

now before us. These separately trained, and certainly
the kind of adjustment will be complicated. Whether
it is more complicated than it is now --



Fidler

10032

1
2
3
4 THE CHAIRMAN: Your proportion may
5 change.

6 COMMISSIONER VAN WART: Make it more
7 complicated.

8 MISS CARPENTER: We might add, Mr.
9 Chairman, that the fact that the School of Nursing might
10 not be as we have it traditionally and as Mr. Chairman
11 pointed out it is not in every hospital -- in any case,
12 I gather it is around 58 out of over 200 hospitals in
13 Ontario that have a nursing school so that many nurses
14 are trained outside the hospital in which they work
15 later on.

16 In any case, the fact that the nursing
17 school may not be within the hospital does not mean that
18 the nurse will not receive her clinical experience in
19 the hospital. She will receive it in the hospital and
20 in other health agencies and she will be more competent
21 to actually co-ordinate services because she will not
22 only understand the care of patients in the hospital but
23 she will understand the care of patients in the work
24 which will be co-ordinated in her nursing education which
25 it is not at present for diploma students.

26 COMMISSIONER VAN WART: You are coming
27 to what I had in mind. The university schools are
28 sending their girls in to be trained under graduates.
29 The diploma schools are sending their girls in to be
30 trained and the nurses' aid, and the nurses' assistants
are coming in as graduates with a certain amount of
training. Well now, as I see it, each of those schools
will want their pupils to have certain things in the
hospital. Now who is going to co-ordinate all that from



Fidler

10033

1
2
3
4 the hospital point of view? Are you going to have a
heterogenous group going this way and that way?

5 THE CHAIRMAN: If you are talking
6 about our hospital, Doctor Baltzan and I will make sure
7 we find a way.

8 MISS FIDLER: They receive many kinds
9 of students now. Their program is arranged by their
10 school, amount of work that is thought to be needed,
11 and so on, but this is done within the framework of the
12 policies and administration of the hospital.

13 COMMISSIONER VAN WART: You have a
14 school of nursing in the hospital now.

15 MISS FIDLER: Yes.

16 COMMISSIONER VAN WART: You are going
17 to take that out. You are not going to have that.

18 MISS FIDLER: No.

19 COMMISSIONER VAN WART: How are you
20 going to fill that vacuum?

21 MISS CARPENTER: Your vacuum, if I
22 may answer sir, would certainly have to be filled by
23 graduate staff if you weren't going to use students.

24 COMMISSIONER VAN WART: Graduate staff
25 of which?

26 MISS CARPENTER: Of R.N.s. Your
27 R.N.s, your head group and your diploma graduate will
28 both be R.N.s. They really make up one group.

29 COMMISSIONER VAN WART: Well, will they
30 be the supervisors over the other two groups? Will
they be the ones over the other two groups? The R.N.s?

MISS CARPENTER: Well the R.N.s, what



Fidler

10034

1
2
3
4 I was trying to say was that the diploma group and the
5 university group will both be R.N.s, both be engaged
6 in nursing care, as they are now.

7 So that really constitutes one group.
8 Now it is thought that out of the university group,
9 out of the group who proceed and get a broader education
10 and more depth in education will emerge the people who
11 will later teach nursing, and perhaps direct nursing
12 services and be the team leader, the supervisors in
13 relation to the nursing care of the patient, but I
14 think we do not visualize, as you do, the problems of
15 categories as being any more acute than they are now.
16 Indeed, we would like to see them less acute.

17 We think it would be less acute if
18 we had better prepared R.N.s and we gradually could
19 do away with the nursing assistants. Now, this is in
20 the long distance future but we think with the better
21 qualified R.N.s in schools that would not have the
22 disadvantage of many of our hospital schools today, we
23 would refer larger numbers of students and we would get
24 a more suitable staff for the hospital and we visualize
25 the situation would be improved. And we visualize the
26 situation would be improved.

27 COMMISSIONER VAN WART: Increasing of
28 the nursing assistants will now become a decreasing
29 group?

30 MISS CARPENTER: Decreasing group, yes.

COMMISSIONER GIRARD: I wonder if one
of Dr. Van Wart's questions has been answered? I think
he was trying to find out who would co-ordinate on the



Fidler

10035

ward, the work of the nursing assistants and all the categories.

We do have those categories now I believe on the wards and the co-ordinator is the head nurse or the team leader. I think this is not anything that would change. Is this what you were trying to get at?

COMMISSIONER VAN WART: That is what I wanted to get.

COMMISSIONER GIRARD: I don't want to answer the question. I am just trying to get the two parties to understand the question. I think that is what you had in mind. We have this now and the co-ordinator is either the head nurse or under the head nurse, the team leader so this will be the same. Is that your opinion?

MISS CARPENTER: Yes.

COMMISSIONER BALTZAN: You will be sure to leave this question not in the hands of the doctors, please.

COMMISSIONER GIRARD: On page 2, recommendation number 8, you say that scholarships, bursaries and loans should be made available where necessary for students of both groups defined in recommendation 5 and for graduate study.

This question of bursaries did come up last week, I believe, when we discussed the brief of the Canadian Conference of University Schools, and I don't know whether this is the same in all provinces but there seems to be a divergence of opinion on the

ward, the work of the nursing assistants and all the

categories,

We do have to see categories now.

Believe in the work and the co-ordination is the head nurse on the team is for. I think this is not anything that would change. Is this what you were trying to get

CONSTITUTIONAL LAW: That is what

I wanted to get.

CONSTITUTIONAL LAW: I don't want

to answer the question. I am just trying to get the two parties to understand the question. I think that

is what you had in mind. We have this now and the

co-ordination is either the head nurse or under the head

nurse, the team leader as this will be the same, is

that your opinion?

MISS CARPENTIER: Yes.

CONSTITUTIONAL LAW: You will be

able to leave this question not in the hands of the

doctors, please.

CONSTITUTIONAL LAW: You say that relationships,

relationships and things should be made available where

an essay for students of both groups dealing in

research and for graduate study.

This question of priorities did come

up last week, I believe, when we discussed the report of

the Canadian Conference of University Schools, and I

don't know whether this is the same in all provinces

but there seems to be a divergence of opinion on the



Fidler

10036

1
2
3
4 available bursaries for certain categories of student
5 nurses and mainly, I believe the main difference is the
6 basic course of nurse student. Now you had a
7 recommendation on that.

8 Would you give us your opinion on
9 the type of bursaries that are needed and where they
10 are more needed than others?

11 MISS FIDLER: It is primarily, I
12 think, a matter of redistribution. All we have in mind
13 although probably more could be used, I will ask Miss
14 Carpenter to speak to this.

15 MISS CARPENTER: As we have heard
16 before, in earlier briefs from the nursing profession,
17 we have had the benefit of National health grant bursaries
18 going to nurses, these have gone from the Federal to
19 the Provincial Government and they have had an effect
20 in upgrading the preparation of nurses, particularly in
21 fields such as public health nurses, public health
22 nurses administration. They have been designed to
23 quickly prepare nurses and so they have given this
24 bursary assistance primarily to the graduate of the
25 hospital school who in a one-year certificate course will
26 get some preparation in these special areas and as you
27 see in the last table in the brief we have the figures
28 here for the 1961 school year and the largest proportion
29 of bursary assistance went to students in these one-year
30 courses.

We feel it is unfortunate that this
money is not distributed more broadly both to the
hospital graduate who will pursue a degree course and get

available primarily for certain categories of student
nurses and finally, I believe the main difference is the
basic course nurse student. Now you had a
recommendation on that.

Would you give us your opinion on
the type of courses that are needed and where they
are more needed than others?

MISS TIDDER: It is primarily, I
think, a matter of redistribution. All we have in mind
although probably more could be used, I will ask Miss
Gardner to speak to this.

MISS GARDNER: As we have heard
before, in earlier briefs from the nursing profession,
we have had the benefit of National Health Grant priorities
going to nurses, there have come from the Federal to
the Provincial Government and they have had an effect
in upgrading the preparation of nurses, particularly in
fields such as public health nurses, public health
nurses administration. They have been directed to
quickly prepare nurses and so they have given this
primary assistance primarily to the graduate of the
hospital school who is a one-year certificate course with
out some preparation in these special areas and as you
see in the last table in the brief we have the figures
need for the 1961 school year and the largest proportion
of primary assistance went to students in these one-year
courses.

We feel it is unfortunate that this
money is not distributed more broadly both to the
hospital graduate who will pursue a degree course and to



1
2
3
4 a broader preparation that will better fill her for
5 senior responsibility, and also to students in the
6 under-graduate program who come from high school and
7 wish to go through a four-year preparation which includes
8 preparation in public health nursing and we do find
9 in some of the regulations of the Province, particularly
10 being in Ontario we know what the problems in Ontario
11 are, that a rider has been put on this National Health
12 Grant Bursary that it is only given to graduates who
13 have already had one year's experience in nursing and
14 the basic course students who are qualifying for public
15 health nursing, as part of their courses, do not
16 qualify for any National Health Grant Bursary, although
17 their course is so much more expensive than the course
18 for the student who is graduating from the hospital
19 school and has received free room and board for three
20 years, and has had no fee to pay and she in one year
21 is getting a very minimal preparation, which we think
22 is too minimal for some of the senior responsibilities
23 she is taking.
24
25
26
27
28
29
30



Carpenter

10038

1
2
3
4 COMMISSIONER GIRARD: In other words,
5 Miss Carpenter, you would like to see the student in
6 the basic degree course in her last year, when she is
7 being prepared for public health nursing, she is
8 getting the same preparation as the one-year certificate
9 course?

10
11 MISS CARPENTER: Throughout the four
12 years, yes.

13
14 COMMISSIONER GIRARD: And they can get
15 a bursary for that year she is being prepared at the
16 same level to do the same thing, but because she is at
17 the basic degree course, she does not get this bursary?

18
19 MISS CARPENTER: We think she is being
20 prepared at a better level.

21
22 COMMISSIONER GIRARD: But this is one
23 thing you would like to see changed?

24
25 MISS CARPENTER: Yes.

26
27 COMMISSIONER GIRARD: Have you any
28 idea as to the amount of bursaries?

29
30 MISS CARPENTER: Miss King advises
these young students in their first year. The amount
given in the National Health Grant Program includes fees
and an amount for room and board. It amounts to about
\$1,200 or \$1,400 a year going to these graduate nurses
for one year. The amount given through Dominion-Provin-
cial bursaries is much smaller. The average amount an
undergraduate student gets is about \$300, whereas the
average amount a graduate gets for one year's course is
\$1,400.

COMMISSIONER GIRARD: What do you say



Carpenter 10039

she should get?

MISS CARPENTER: If she cannot live at home, and cannot provide her room and board, or pay for it, she needs \$1,400, of course.

MISS KING: I think this is not only applicable to a basic course student in her last year. These students certainly need bursary assistance before their last year. I think their re-distribution would be in terms of the total four-year course, because a girl on that course is being prepared for public health work, of course, and for hospital work.

COMMISSIONER GIRARD: But in the last year she seems to be discriminated against, if you compare what she is getting, or not getting, with what the graduate nurse is getting?

MISS KING: True, but there is need for an increased amount of assistance in other than the last year.

COMMISSIONER GIRARD: Would you say that the need is 12 to 14 a year?

MISS KING: I think 14 to 15 hundred a year during the four years.

COMMISSIONER FIRESTONE: Miss Fidler, on page 9, paragraph 15, your brief says that, I quote:

"Canada has one of the highest ratios of nurses to population in the world."

Everyone is constantly concerned about the shortage of nurses. Do you and your associates agree with this view, that there is a shortage of nurses in Canada?



and should not?

MISS CLARK: It is not five

at home, and cannot provide for room and board, or pay

for it, and needs \$1,000, or more.

MISS KIM: I think this is not only

applicable to a basic course student in her last year.

These students certainly need money, assistance before

their last year. I think their re-distribution would

be in terms of the total four-year course, because

that on that course is being, prepared for public health

work, of course, and for hospital work.

(MISS KIM: But in the last

year she seems to be disappointed again, it is

compared with one in getting, or not getting, with what

the graduate nurse is getting?

MISS KIM: True, but there is need for

an increased amount of assistance in other than the last

year.

COMMISSIONER: Would you say

that the need is 12 to 14 years?

MISS KIM: I think 14 to 15 hundred

a year during the four years.

Page 6, paragraph 16, you will say that, I quote:

"Canada has one of the highest ratios

of nurses to population in the world."

Everyone is constantly concerned about

the shortage of nurses. To you and your associates

with this view, that there is a shortage of nurses

in Canada.



Fidler

10040

MISS FIDLER: I think there is probably some numerical shortage, though I don't know that everyone agrees with this, but I think that there is a shortage of quality, which might help to overtake, at least to some extent, the numerical shortage.

MISS CARPENTER: One area where we recognize a distinct shortage of nurses is in the mentally ill. This area had the last consideration and perhaps will improve gradually over a period of years now.

COMMISSIONER FIRESTONE: How about in the other area?

MISS CARPENTER: Well, I think the other area that we hear most of shortages is in the outlying areas of Canada, the outpost areas. Again, the introduction of prepaid hospital care plans have done something to stabilize nursing staff, in that the salaries in these smaller hospitals have been brought up to a better level.

COMMISSIONER FIRESTONE: We have heard a number of proposals how to encourage more young women to enter the field of nursing. This is an approach whereby you can increase the number of nurses. I wonder whether you and your associates, Miss Fidler, have given some thought or have any suggestions to offer to this Commission about the more effective utilization of the time that nurses should devote to nursing?

MISS FIDLER: I think we are aware that this needs studying. We understand that a study is being done. I would like to ask Miss Wilson if she



MISS ELLIOTT: I think there is probably
some numerical shortage, but I don't know that every-
one agrees with this, but I think that there is a shortage
of quality, which might help to overcome, at least to
some extent, the numerical shortage.

MISS CALVERT: The area where we
recognize a distinct shortage of nurses is in the
mentally ill. This area had the last consideration
and perhaps will improve gradually over a period of
years now.

COMMISSIONER ELLIOTT: How about in
the other area?
MISS CALVERT: Well, I think the
other area that we hear most of shortages is in the
outlying areas of Canada, the outpost areas. Again,
the introduction of general hospital care plans have
done something to stabilize nursing staff, in that the
situation in these smaller hospitals have been brought
up to a better level.

COMMISSIONER ELLIOTT: We have heard
a number of proposals now to encourage more young women
to enter the field of nursing. This is an approach
whereby you can increase the number of nurses. I wonder
whether you and your associates, Miss Eddies, have given
some thought or have any suggestion to offer to this
Commission about the more effective utilization of the
time that nurses would devote to nursing?

MISS ELLIOTT: I think we are aware
that this needs studying. We understand that a study
is being done. I would like to ask Miss Wilson if she



Fidler

10041

has definite suggestions from her experience in the ward, as to how this might be done.

MISS WILSON: I would think, sir, that there are several angles to this. One is that it is essential that in the preparation of the young student she has a chance to study nursing in its fullest sense, so that when she has become a graduate her idea of nursing is not restricted to diagnosis and procedures. I think this is a fairly common complaint of many of our graduates and I think that a great deal, of course, in our hospital situation depends upon the calibre of the graduate staff, and their understanding of how the nurses' time should be spent.

In some instances, they are unable to practise what we would think of as being good nursing care, and in others there is not bad opportunity.

COMMISSIONER FIRESTONE: Well, what happens to a registered nurse in those other cases? Is she asked to perform manual tasks that really are not the responsibilities of a registered nurse?

MISS WILSON: I think the situation is very markedly, yes, she is carrying on tasks for which her preparation was not necessary, and I think it is also true that in some instances she does not know how to utilize her time.

COMMISSIONER FIRESTONE: Is that the nurse's fault, or is that the management of the hospital's fault?

MISS WILSON: It could be both. I think part of it could be the fault of those of us who



Wilson

10042

1
2
3
4 have been responsible for teaching young nurses. You
5 will recollect that one of the criticisms frequently
6 afforded is that nurses are sitting around the desks
7 and we also know, at the same time, that many patients'
8 needs have not been met and some of us feel that part
9 of the reason for that is they don't comprehend what
10 the patients' needs are, or they know what the needs
11 are, but don't know how to meet them and therefore
12 avoid them.

13 COMMISSIONER FIRESTONE: You say this
14 point has been recognized by those who teach nursing.
15 What has been done about it?

16 MISS WILSON: Well, this leads into the
17 other question. Many of us feel that education must be
18 separated from service and also I believe it is true
19 that - what is the word you use? Technical work, technical
20 skills, are important, but they can dull imagination
21 after a while so that young students should have a
22 chance to practise their nursing in their learning years,
23 while they can develop imagination and initiative and
24 energies of thought, etc., and not be stifled.

25 It seems to me that we can justify
26 this statement in the fact that many of our young
27 graduates apparently turn away from the pleasure of
28 bedside nursing in their last year. Something happens.
29 So that we are inclined to think that the blame lies on
30 those who handle the young nursing students. They don't
have a chance to practise nursing and get the satisfaction
from it.

COMMISSIONER FIRESTONE: Why would a



I have been responsible for teaching young nurses. You will recall that one of the criticisms frequently leveled is that nurses are without spirit and initiative and we also know, at the same time, that many patients' self have not a word and some of us feel that part of the reason for that is they don't comprehend what the physical needs are, or they know what the needs are, but don't know how to meet them and therefore

COMMISSIONER TRISTAN: Now say this

point has been recognized by those who teach nursing.

That has been done about it?

TRISTAN: Yes, this leads into the

other question. Many of us feel that education must be

separated from service and also I believe it is true

that - what is the first you need? Technical work, technique

skills, are important, but they can only insulate

against what is the best, and students should have a

chance to experience their nursing in their learning years,

while they can exercise imagination and initiative and

exercise of thought, etc., and not be drilled

It seems to me that we can justify

this element in the fact that we - of our young

graduates are entirely torn away from the pleasure of

bedside nursing in their last year. Something happens,

so that we are inclined to think that the time has come

those who handle the young nursing students. They don't

have a chance to practice nursing and get the satisfaction

COMMISSIONER TRISTAN: Now say this



Wilson

10043

nurse who is asked to perform manual tasks not go to management in the hospital and say: "I have been hired as a nurse but you are not using me as a nurse, you are using me as a part-time nurse", and see that the situation be remedied? Why cannot the nurses speak up for themselves, if they have been taught what to do?

MISS WILSON: Well, for quite a few years we were not taught to speak up.

COMMISSIONER FIRESTONE: Well, are they being taught now?

MISS WILSON: I hope so.

MISS FIDLER: I think that it is not so much a matter of being asked to do things which are beneath a nurse, which do not require her full skill and so on, manual things, but this confused situation, this increasing number of categories has created more and more administration work, which removes the most highly-qualified nurses from the patient more and more, and I think it is that kind of utilization, and the difficulty of co-ordinating this very complicated situation, with so many groups, so that not only are some accepting responsibility below their capacity, but others above, which is, I suppose, even worse.

COMMISSIONER FIRESTONE: But what is being done at teaching level to drive home the point that you are training nurses to perform certain functions and they should speak up when there is ineffective use of their time and capabilities in a hospital? Is anything done in the educational program?

MISS FIDLER: A good deal.

... who is asked to perform manual tasks not so to
management in the hospital and say: "I have been right
as a nurse but you are not using me as a nurse, you are
using me as a part-time nurse", and see that the
situation be remedied. Why cannot the nurses speak up
for themselves, if they have been taught what to do?
... well, for only a few
years we were not taught to speak up.

COMMISSIONER FIRSTONE: Well, are

they being taught now?

MISS WILSON: I hope so.

MISS LINDER: I think that it is not

so much a matter of being asked to do things which are
beyond a nurse, which do not require her full skill
and so on, manual things, but this confused situation,
this increasing number of categories has created more
and more administration work, which removes the most
highly-qualified nurses from the patient more and more,
and I think it is that kind of utilization, and the
complexity of co-ordinating this very complicated
situation, with so many groups, so that not only are
some accepting responsibility below their capacity, but
others above, which is, I suppose, even worse.

COMMISSIONER FIRSTONE: But what is

being done at teaching level to drive home the point
that you are training nurses to perform certain functions
and then should speak up when there is ineffective use
of their time and capabilities in a hospital? Is any-
thing done in the educational program?
MISS LINDER: A good deal.



Carpenter

10044

MISS CARPENTER: We would like to see and are very anxious to have the opportunity to show again what can be done in the education of nurses if service and education are separated. We feel that the young student is too often in a service situation, where the demands are above her level of skill in her early years of preparation, and she has too little instructor time at this stage of her development and I think if you had the opportunity to look at the study of 25 schools done recently, and you observed the amount of time students in service from four to midnight, and midnight to eight, and these are times when there are not instructors with the students and so we feel it was shown in the Metropolitan and the Nightingale Schools, and in our own university school, that students can be taught to nurse with greater economy of time and effort, and in a better way to understand what nursing is, and we would like very much to see further opportunity to experiment in this way and help the young student to learn more quickly and more effectively, what nursing is and then, as a graduate, to be a more effective person in the situation.

COMMISSIONER GIRARD: Mr. Chairman, to come back to this poor utilization. Would you agree that poor utilization stems very often from lack, or inadequate preparation of the head nurse, or the person in charge of the student nurses or of the nurse that is doing the nursing? Do you agree that that is one of the reasons for poor utilization?

MISS FIDLER: Well, I think we must say



and are very anxious to have the opportunity to show
again what can be done in the education of nurses if
service and education are separated. We feel that the
young student is too often in a service situation,
where the demands are above her level of skill in her
early years of preparation, and she has too little
instructor time at this stage of her development and
I think if you had the opportunity to look at the study
of 25 schools done recently, and you observed the amount
of time students in service from four to midnight, and
midnight to eight, and these are times when there are
not instructors with the students and so we feel it was
shown in the Metropolitan and the Nightingale Schools,
and in our own university school, that students can be
taught to nurse with greater economy of time and effort,
and in a better way to understand what nursing is, and
we would like very much to see further opportunity to
experiment in this way and help the young student to
learn more quickly and more effectively, what nursing
is and then, as a graduate, to be a more effective
person in the situation.

to come back to this poor utilization. Would you agree
that poor utilization stems very often from lack, or
inadequate preparation of the head nurse, or the person
in charge of the student nurses or of the nurse that
is doing the nursing? Do you agree that that is one
of the reasons for poor utilization?

MISS FIDLER: Well, I think we must say



Fidler

10045

that the Director of Nursing Services must have something to say, should have something to say, but some can organize better than others. Nevertheless, I think that there are situations which, aside from these categories and so on, tend to be perpetuated. The things that the nurse has to do in the middle of the night, because there is no one else there. This 24-hour continuity makes it very natural that a good many things should be delegated at that time and perhaps this is all right, but it does certainly require more study.

COMMISSIONER FIRESTONE: This subject of effective utilization of nurses is quite a complicated subject. We appreciate that, and I think your point was well taken when you said this would require more study.

I am just wondering if, in the process of you and your associates giving such thought to the matter, you have any specific suggestions to put forward that could help to come to grips with this problem of more effective utilization of the nurses' time for nursing duties, we would appreciate it greatly if such thoughts could be communicated to this Commission in the form of a written letter to our Secretary.

MISS FIDLER: We will be glad to do that.

COMMISSIONER FIRESTONE: And thank you very much, Miss Fidler and ladies.

THE CHAIRMAN: I want to add my thanks, Miss Fidler.

COMMISSIONER VAN WART: Turning to page 5,

that the Inspector is Training Committee must have something

... things
that the nurse has to do in the middle of the night,
because there is no one else there. This 24-hour
continuity makes it very natural that a good many
things should be delegated at that time and perhaps
this is all right, but it does certainly require more
staff.

COMMENTARY: This subject
of effective utilization of nurses is quite a complicated
subject. We appreciate that, and I think your point

I am just mentioning it, in the process
of you and your associates giving such thought to the
matter, you have my sincere suggestions to put forward
that could help to come to grips with this problem of
more effective utilization of the nurses' time for
nursing duties, we would appreciate it greatly if such
thoughts could be formulated to this Commission in the
form of a written letter to our Secretary.

MR. TISHMAN: We will be glad to do that.

MR. TISHMAN: Thank you. And thank you

very much, Miss Felt and ladies.

MR. TISHMAN: I want to add my thanks,

Thank you very much. Thank you very much.



Carpenter 10046

section 8, you state that:

"In the development of health services, priority should be given to 1, 2 and 3."

By priorities you mean priorities over No. 7, or do you mean that -- what had you in mind?

MISS CARPENTER: I think what we would support, the discussion in the brief that came before, in that we would recognize that although it is desirable to have health services freely available to people so that they could be cared for in the hospital and at home, and the care of patients with long-term illnesses would be of the same quality as the acute illnesses, and so on.

We recognize that we cannot alter a situation immediately, and I think we recognize that any provision for improving preventable illness would be a high priority, as well as improving the care of people who are mentally ill, and trying to learn to co-ordinate home care with the hospital care.

We, as nurses, recognize that very frequently a patient is discharged from hospital to a situation where they are not fully able to cope with the care at home, and they perhaps arrive back in hospital again, receiving expensive treatment, when they might have stayed at home with a little support; so that we would give priority to these areas.

section 8, you state that:

"In the development of health services,

priority should be given to 1, 2 and

3."

By priorities you mean priorities over

40. 7, or do you mean that -- what was your mind?

MISS CARPENTER: I think what we would

support, the discussion in the brief that came before,

in that we would recognize that although it is desirable

to have health services freely available to people so

that they could be cared for in the hospital and at home,

and the care of patients with long-term illnesses would

be of the same quality as the acute illnesses, and so

We recognize that we cannot alter a

situation immediately, and I think we recognize that

any provision for improving preventable illness would

be a high priority, as well as improving the care of

people who are mentally ill, and trying to learn to

co-ordinate home care with the hospital care.

We, as nurses, recognize that very

frequently a patient is discharged from hospital to a

situation where they are not fully able to cope with

the care at home, and they perhaps arrive back in

hospital again, receiving expensive treatment, when

they might have stayed at home with a little support;

so that we would give priority to these areas.



10047

COMMISSIONER VAN WART: Coming to recommendation 3, a Provincial advisory committee on health services be established in each Province. Do you give priority to that?

MISS CARPENTER: We would think that any assistance that could be given by better planning should be given, receive high priority. We too realize the problem of the number of different services we now have that could be coordinated more successfully. We would support what the Victorian Order of Nurses brought out. Their services are much cheaper than the service of in-patient day care, but they are not being fully utilized. It is a matter of planning and coordinating these services and seeing they play the full extent in order to make better use of the services available.

COMMISSIONER VAN WART: You give priority to the establishment of such?

MISS CARPENTER: Yes.

THE CHAIRMAN: Thank you again, Miss Fidler. As I was saying, we have had a number of nursing organizations in all the provinces, V.O.N. and so forth. We have always had a good audience when we have a nursing presentation being made. I may say on behalf of my associates of all the delegations that have come forward with presentations we have not seen any more dedicated group or more pleasant to discuss their problems with.

MISS FIDLER: Thank you.

THE SECRETARY: The next submission will be of the Banting and Best Department of Medical Research, University of Toronto. It will be known as

CONFIDENTIAL - Mr. WARD: Coming to

health services in a hospital in an Province. Do you
give priority to that?

any assistance that could be given by better planning
should be given, receive high priority. We too realize
the number of the number of different services we now
have that could be coordinated more successfully. We
would support what the Victorian Order of Nurses brought
out. These services are much broader than the service of

in-patient day care, but they are not being fully
utilized. It is a matter of planning and coordinating
these services and seeing they play the full extent in
order to make better use of the services available.

CONFIDENTIAL - Mr. WARD: You give

priority to the establishment of such

THE CHAIR: Thank you again, Miss

Ward. As I was saying, we have had a number of nursing
organizations in all the provinces, V.O.N. and so forth.
We have always had a good alliance when we have a nursing

organization being made. I may say in fact I am very
associated with all the organizations that have come forward
with presentations we have not seen. I am more dedicated
group of people pleasant to discuss their problems with.

THE CHAIR: Thank you.

will be of the British and have been instrumental in the
research, University of Toronto. It will be known as



Exhibit 277. Dr. Best is here to read his submission.

S U B M I S S I O N O F
THE BANTING AND BEST DEPARTMENT OF MEDICAL RESEARCH OF THE
UNIVERSITY OF TORONTO

EXHIBIT NO. 277: Submission of the Banting
and Best Department of
Medical Research, Univer-
sity of Toronto.

APPEARANCES:

DR. C. H. BEST

DR. BEST: May I sit down?

THE CHAIRMAN: If you will. We try
to be informal, Dr. Best.

DR. BEST: Do you wish me to go ahead
now?

THE CHAIRMAN: Please.

DR. BEST: I can speak only for the
Banting and Best Department of Medical Research of the
University of Toronto. I would like to put in a plea for
more opportunities for full-time medical research in
Canada. I think we are lagging behind very greatly and
need far more than we have available. I realize in a
teaching department the first obligation is to teaching the
students. There is no doubt about that. There has been
a tendency, I think, to encourage people to do teaching and
research at the same time. Many people make a splendid
success of that, but on the other hand, there are those



Best 10049

who feel that full-time is little enough when you are tackling a difficult research problem. There are actually extremely few opportunities in Canada for people who wish to spend their full time in research. The result has been they go elsewhere, either to England or to the United States where they can get opportunities for full-time research.

I think the history of the Banting and Best Department of Medical Research is well-known. It was set up directly responsible to the President of the University of Toronto. It attracts graduate students from all over the world. Last week we had four Ph.D. students. They got their degrees through teaching departments of physiology, but they came from widely separate parts of the world. There are many more who have been attracted into research in Canada because of the existence of this opportunity for full-time work. The physical facilities are adequate in this particular department. We need some further endowments, of course, as almost all departments do, but I expect we will be able to get them. The recommendations are that the Banting and Best Department of Medical Research be supported as an independent research and graduate teaching unit in the University of Toronto, and that consideration should be given to creating more essentially full time opportunities in Canada both in research institutes and in Departments of Faculties of Medicine so that scientists who are determined to devote their full energies to investigation will find adequate facilities in a university environment and in their own country.

who feel that full-time is little enough when you are
 tackling a difficult research problem. There are actually
 extremely few opportunities in Canada for people who
 wish to spend their full time in research. The result
 has been they go elsewhere, either to England or to the
 United States where they can get opportunities for full-
 time research.

I think the history of the Banting and
 Best Department of Medical Research is well-known. It
 was set up directly responsible to the President of the
 University of Toronto. It attracts graduate students
 from all over the world. Last week we had four Ph.D.
 students. They got their degrees through teaching depart-
 ments of physiology, but they came from widely separate
 parts of the world. There are many more who have been
 attracted into research in Canada because of the existence
 of this opportunity for full-time work. The physical
 facilities are adequate in this particular department.
 We need some further equipment, of course, as almost all
 departments do, but I expect we will be able to get them.
 The recommendations are that the Banting and Best Depart-
 ment of Medical Research be supported as an independent
 research and graduate teaching unit in the University of
 Toronto, and that consideration should be given to creating
 more and fully full time opportunities in Canada both
 in research institutes and in departments of faculties of
 medicine so that scientists who are determined to devote
 their full energies to investigation will find adequate
 facilities in a university environment and in their own



Best 10050

I think that is the essence, Mr. Chairman, of what I was to present.

COMMISSIONER FIRESTONE: Dr. Best, does the Federal Government make a financial contribution to research work of the Banting and Best Department of Medical Research?

DR. BEST: Yes, we get grants from the new Medical Research Council, a modest grant, and we also have grants from the Defence Research Board. We don't find that sufficient, of course, and we go elsewhere for grants and we get grants from the United States and we get grants from England.

COMMISSIONER FIRESTONE: What sum have you received in the last year?

DR. BEST: From the Government of Canada?

COMMISSIONER FIRESTONE: From the Government of Canada.

DR. BEST: In the neighbourhood of \$50,000.00, I think.

COMMISSIONER FIRESTONE: What would you consider an appropriate research grant per annum from the Federal Government?

DR. BEST: You mean the total or for my Department?

COMMISSIONER FIRESTONE: Total for your Department, a figure comparable to the \$50,000.00.

DR. BEST: Well, I am thinking of asking another agency for \$70,000.00 a year now. If I had that from Canada, I wouldn't ask the other agencies.



Best 10051

COMMISSIONER FIRESTONE: The other agencies are agencies outside of Canada?

DR. BEST: Outside of Canada.

COMMISSIONER FIRESTONE: And you feel that a Federal Government contribution of \$50,000.00 plus \$50,000.00 --- \$120,000.00 and you would be adequately financed to undertake the program that you have presently planned?

DR. BEST: Yes.

COMMISSIONER FIRESTONE: Is that correct, sir?

DR. BEST: Yes, we have no more space. The building is not designed for any more space. We have all the staff that we need, all the physical facilities. The increase in research grants is the only thing we lack.

COMMISSIONER FIRESTONE: And you recommend that this sum be raised from \$50,000.00 to \$120,000.00?

DR. BEST: It would be much better if came from Canada.

COMMISSIONER VAN WART: Dr. Best, the monies you get for grants are for a specific project?

DR. BEST: Not really. We have had a consolidated grant over the years which permits the head of the Department to divide it up almost as he likes. We have had great freedom in that. We now have a block grant that is divided up among five different groups.

COMMISSIONER VAN WART: Would you prefer a system of grants for projects or for a department

agencies and services outside of Canada?

Q. Yes; Outside of Canada.

COMMISSIONER: And you feel

that a Federal Government contribution of \$50,000.00 will

be \$10,000.00 -- \$100,000.00 and you would be absolutely

financial to undertake the program that you have presently

planned?

MR. BENT: Yes.

COMMISSIONER: Is that

correct, sir?

MR. BENT: Yes, we have no more space.

The building is not designed for any more space, we have

all the staff that we need, all the physical facilities.

The increase in research grants is the only thing we

COMMISSIONER: And you

recommend that this sum be raised from \$20,000.00 to

\$100,000.00?

MR. BENT: It would be much better if

came from Canada.

COMMISSIONER: All right; the

series you get for grants are for a specific project?

MR. BENT: Not exactly, we have had a

consolidated grant over the years which permits the use of the

Department to divide it up amongst as he likes. We have

had great freedom in that. We now have a block grant

that is divided up among the different groups.

COMMISSIONER: All right; would you

recommend a series of grants for projects as for a department?



Best 10052

to use as they choose?

DR. BEST: Well, I think you could have a mixture of those. Certainly people who are completely independent, senior people I think, they should have their own within the department. Sometimes when you have a series of junior people it is better to have the head of the department or some individual to have a block grant and divide it up among them. We have had no difficulty of that type of grants at all.

COMMISSIONER FIRESTONE: Do you have an adequate number of graduates from Canadian universities of high calibre that come to you to do this type of research?

DR. BEST: They come from all over the world.

COMMISSIONER FIRESTONE: I appreciate that. I think you said that a little earlier. I am interested to see whether Canadian graduates have the opportunity to do this type of research. We have had complaints in other places that many of them don't have the opportunities and they have to go to the States or other countries to do so, and once they go abroad many of them are lost to Canada. Therefore, my question is what are the opportunities for Canadian graduates to do this type of research at your institute?

DR. BEST: We would give preference to Canadian graduates if they were available. We have to start much further back with the training of the people from other countries. We have to usually ask them to take their Ph.D. degree, which means taking two or three



1963

Dr. Hest: Well, I think you could

have a mixture of those. Certainly people who are

concentrated in certain areas, as on people I think, they

should have their own within the department. Sometimes

when you have a series of junior people it is better to

have the head of the department or some individual to

have a block grant and divide it up among them. We have

had no indication of what type of grants at all.

COMMISSIONER: Do you have

an adequate number of graduates from Canadian universities

of high calibre that come to you to do this type of

Dr. Hest: They come from all over the

COMMISSIONER: I appreciate

that. I think you said that a little earlier. I am

interested to see whether Canadian graduates have the

opportunity to do this type of research. We have had

complaints in other places that many of them don't have

the opportunities and they have to go to the States or

other countries to do so, and once they do abroad many

of them are lost to Canada. Therefore, my question is

what are the opportunities for Canadian graduates to do

this type of research at your institution?

Dr. Hest: We would give preference to

Canadian graduates if they were available. We have to

start with the training of the people

in other countries. We have to usually ask them to take

their own degrees, with a year or two or three



Best 10053

fundamental subjects, and then bringing them up and keeping them later. I have been struggling for 40 years to keep medical research in Canada.

COMMISSIONER FIRESTONE: A very laudable objective.

DR. BEST: Well, it is, but one has doubts occasionally, because I know 30 or 40 young Canadians who would have contributed more to the world if they had left Canada. They haven't had the opportunity in other universities. It would have been better if they had gone. At the same time I think we are struggling to keep them in Canada. I am not so sure about it sometimes.

THE CHAIRMAN: I suppose you would want reciprocity, want to be completely mobile.

DR. BEST: Interchange is wonderful, but I think we should --- we are beginning to attract more of our own people back from the United States. I think there has been a period now when a lot of people haven't realized their full potential because their loyalty has kept them in Canada, a lot of medical research people.

COMMISSIONER BALTZAN: In what way are they hindered?

DR. BEST: They have been inundated with teaching responsibilities when their desire was to do research. They have tried to do both, and they have failed in their research because they haven't had the time and that has had to go.

THE CHAIRMAN: Dr. Best, that may bring in the side-door something we discussed here on Friday;



Best 1967

fundamental subjects, and then bringing them up and
keeping them later. I have been struggling for 40 years
to keep medical research in Canada.

objective.

MR. BEST: Well, it is, but one has

donate occasionally, because I know 30 or 40 young
Canadians who would have contributed more to the world
if they had left Canada. They haven't had the opportunity
in other universities. It would have been better if they
had gone. At the same time I think we are struggling to
keep them in Canada. I am not so sure about it sometimes.

THE CHAIRMAN: I suppose you would

want reciprocity, want to be completely mobile.

MR. BEST: Interchange is wonderful,

but I think we should -- we are beginning to attract
more of our own people back from the United States. I
think there has been a period now when a lot of people
haven't realized their full potential because their
loyalty has kept them in Canada, a lot of medical research
people.

THE CHAIRMAN: In what way are

they different?

MR. BEST: They have been inundated

with research opportunities when their desire was to
to research. They have come to both, and they have
failed in their research because they haven't had the
time that they had to go.

THE CHAIRMAN: Mr. Best, that may bring

to the side-order something we discussed here on Friday;



Best 10054

that is the location of research institutions as an integral part of universities or as a separate institution which would have no teaching load.

DR. BEST: Yes, that is a problem I would like to discuss. I am very keen about it, because I worked for some years at the National Institute of Medical Research at England. They have hundreds of young people who have opportunity for full-time research. We have none, no Government research institute for medicine.

THE CHAIRMAN: The organization of Canadian Medical Colleges, their recommendation was that these research institutes should not be separate entities, but a part of the university, a part of the medical school setup.

DR. BEST: My recommendation would be they should not always be that. If tradition or opportunity comes to give them a separate entity you might get a much better type of person. I think both should be done. Mind you, some people will work best at research in the atmosphere of a teaching institute, and some people will not work under those circumstances. I think the whole of history --- I was at the Nobel Prize ceremonies last year and the two people who got prizes were in full-time research institutes, one in Australia and one in England. That has been history. There are thousands of examples. On the other hand, I think it is a nice tidy arrangement to have research at a teaching department if it works beautifully, perfectly, that is fine, but it wouldn't always work, so I think that both should be available where there is the opportunity for it. There

that is the location of research institutions as an
integral part of the university or as a separate institution
which would have no teaching load.

Q. Now, yes, that is a problem.

A. I would like to discuss it. I am very keen about it, because

I worked for some years at the National Institute of
Medical Research at Beijing. They have hundreds of young
people who have opportunity for full-time research. We
have none, no Government research institute for medicine.

Q. The Chairman: The organization of

research institutes should not be separate entities,
but a part of the university, a part of the medical school
etc.

A. Yes, by recommendation would be

Q. They should not always be that. If tradition or opportunity

allows to give them a separate entity you might get a

much better type of person. I think both should be

done. Ming (sic), some people will work best at research

in the atmosphere of a teaching institute, and some

people will not work under those circumstances. I think

one kind of institution -- I was at the Nobel Prize ceremonies

last year and the two people who got prizes were in 1911-

two research institutions, one in America and one in

Europe. That was real history. There are thousands of

examples. On the other hand, I think it is a nice thing

to have people who have research as a teaching load, that

it would be a good thing, really, that is true, but it

would be a little worse, I think that both should be

done. It would be a good thing to have opportunity for it. There



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

Best 10055

might be one pattern and you could just kill things
by making them all fall under one pattern.



100

100

...for our defense and you could just kill things
...making them ... under one defense.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100



Best

10056

COMMISSIONER McCUTCHEON: You are not suggesting a divorce in your own case?

DR. BEST: Well, I have a divorce, I am not in the medical faculty. Mind you, I have no real brief for government research institute. I think Canada has been wise that only our universities ---

THE CHAIRMAN: I think it is putting it a little closer to what the medical school ---

COMMISSIONER McCUTCHEON: You are distinguishing between being part of the school and part of the university?

DR. BEST: I think we are wise in being part of the university.

COMMISSIONER FIRESTONE: Do you feel the National Research Council has not made a contribution even though it is government operated?

DR. BEST: Well, I know the National Research Council very well, it has made great contributions but those of us who have been consulted on development of medical research in Canada think we have not reached the point where we should push hard for a central government institute of medical research. We think it is in the best interest of Canada to develop the medical research within the universities. Some day this other might come as it has come in many different countries.

COMMISSIONER FIRESTONE: How many research people are presently working at the Banting and Best Department of Medical Research?

DR. BEST: About 40.

THE CHAIRMAN: Now, I am not

expecting a divorce in your own case?

DR. BENT: Well, I have a divorce, I

am not in the medical faculty, and you, I have no

real brief for government research institute. I think

Canada has been wise that only our universities ---

THE CHAIRMAN: I think it is putting

it a little closer to what the medical school ---

COMMISSIONER WOODHOUSE: You are

distinguishing between being part of the school and

not of the university?

DR. BENT: I think we are wise in

being part of the university.

COMMISSIONER FLEMING: Do you feel

the National Research Council has not made a contribu-

tion even though it is government operated?

DR. BENT: Well, I know the National

Research Council very well, it has made great contribu-

tions but those of us who have been concerned on

evolution of medical research in Canada think we have

not reached the point where we should turn part of a

part of government institute of medical research. We

think it is in the best interest of Canada to develop

the medical research within the universities. Some day

this light will come on it has come in very different

stages.

COMMISSIONER FLEMING: Now, may

we have people are essentially working at the Hartman and

best of research in Medical Research

Dr. Bent, about 10.



Best

10057

1
2
3
4 COMMISSIONER FIRESTONE: And how
5 many of those 40 are Canadian citizens?

6 DR. BEST: Well, I cannot quite say
7 but the pattern has been almost invariable that they
8 want to stay and they take out their Canadian citizenship
9 and while they come from all parts of the world a
10 remarkably few of them go back. Our department has
11 been built up very largely over the years with people
12 from other places and I suppose we are entering an era
13 now where our people will either go to other universities
14 in Canada or go to the States. A few of them have
15 always gone back but we have been embarrassed on a number
16 of instances because a number of people have had
17 scholarships to come on the condition that they should
18 return to their countries and have not done so.

19 COMMISSIONER FIRESTONE: Would you
20 feel that there is room in Canada for several Banting
21 and Best departments of medical research?

22 DR. BEST: I think if you can find
23 a tradition across Canada and develop it into a research
24 institute, in Vancouver or Halifax, it would be a grand
25 thing. I think it would add to the prestige and press
26 for medical research in Canada.

27 COMMISSIONER FIRESTONE: You have
28 been very helpful, thank you very much.

29 COMMISSIONER McCUTCHEON: Dr. Best,
30 on page 6, the third clear sentence you say:

"Five new laboratories have become

"available, and these will be filled

"to overflowing without any additions



10037

COMMISSIONER: FIRST: And how

many of those who are Canadian citizens?

MR. BROWN: Well, I cannot quite say

but the pattern has been almost invariably that they

want to stay and they take out their Canadian citizenship

and while they come from all parts of the world a

remarkably few of them go back. Our department has

been built up very largely over the years with people

from other places and I suppose we are entering an era

now where our people will either go to other universities

in Canada or go to the States. A few of them have

always gone back but we have been embarrassed on a number

of instances because a number of people have had

scholarships to come on the condition that they should

return to their countries and have not done so.

COMMISSIONER: FIRST: Would you

feel that there is room in Canada for several banking

and trust departments of medical research?

MR. BROWN: I think if you can find

a tradition across Canada and develop it into a research

institute, in Vancouver or Halifax, it would be a grand

thing. I think it would add to the prestige and power

for medical research in Canada.

COMMISSIONER: FIRST: You have

been very helpful, thank you very much.

on page 6, the third clear sentence you say:

"Five new laboratories have been

"available, and these will be filled

and over the years without any additions



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Best : 10058

"to the staff of the department."

DR. BEST: Yes.

COMMISSIONER McCUTCHEON: You just opened some new research facilities at the Princess Margaret Hospital with the same result. Is that the result of Parkinson's Law in the field of research?

DR. BEST: No, we have a lot of junior people who are just ready to take up chairs of physiology in this country and they moved into these new laboratories and they get their opportunity here. There will not be five new laboratories again in that building, ever again, there is no facility for it, it is full now.

THE CHAIRMAN: Thank you very much, Dr. Best. It was very gracious of you to come and give us the benefit of your advice.

We will meet tomorrow morning at 9:30 in the Senate Chamber at Simcoe Hall.

---ADJOURNMENT.

"to the staff of the department."

Dr. Best: Yes.

opened some new research facilities at the Princess Margaret Hospital with the same result. Is that the result of Parkinson's law in the field of research?

Dr. Best: No, we have a lot of junior

people who are just ready to take up chairs of physiology in this country and they moved into these new laboratories and they got their opportunity here. There will not be five new laboratories again in that building, even again, there is no facility for it, it is full now.

THE CHAIRMAN: Thank you very much.

Dr. Best: It was very gracious of you to come and give us the benefit of your advice.

We will meet tomorrow morning at 8:30

in the Senate Chamber at St. James Hall.

ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

TORONTO

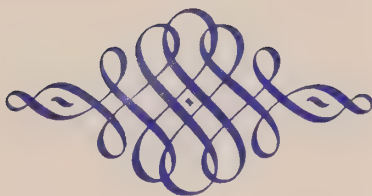
ONT.

VOLUME NUMBER :

53

DATE:

MAY 15 1962



OFFICIAL REPORTERS

ANGUS, STONEHOUSE & CO. LTD.,
BOARD OF TRADE BLDG.,
11 ADELAIDE ST. W.
TORONTO

364-5865

364-7383



ANGUS, STONEHOUSE & CO. LTD
TORONTO, ONTARIO

VOLUME 53

INDEX

Page No.

THE CANADIAN MEDICAL ASSOCIATION

10059

THE CANADIAN THORACIC SOCIETY

10187

THE CANADIAN ORTHOPAEDIC ASSOCIATION

10190

THE CANADIAN OTOLARYNGOLOGICAL SOCIETY

10192

THE CANADIAN LIFE INSURANCE MEDICAL
OFFICERS' ASSOCIATION

10196

THE COLLEGE OF GENERAL PRACTICE OF
CANADA

10199



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

1
2
3 ROYAL COMMISSION ON HEALTH SERVICES
4

5 Proceedings of the hearings
6 held in Toronto, Ontario,
7 on the 15th day of May, 1962.

8 COMMISSION MEMBERS:

9 Chief Justice EMMETT M. HALL -- Chairman

10 Miss ALICE GIRARD, R.N.

11 Dr. C.L. STRACHAN

12 Dr. ARTHUR F. VAN WART

13 Mr. M. WALLACE McCUTCHEON, Q.C.

14 Prof. O.J. FIRESTONE

15 Dr. DAVID M. BALTZAN

16 COMMISSION COUNSEL:

17 Mr. R.N. HALL, Q.C.

18 MEDICAL CONSULTANT:

19 Dr. PIERRE JOBIN

20
21 DIRECTOR OF RESEARCH:

22 Prof. BERNARD BLISHEN

23
24 COMMISSION SECRETARY:

25 Mr. N. LAFRANCE
26
27
28
29
30



10059

Toronto, Ontario,
Tuesday, 15th May, 1962.

--- On commencing at 9.30 a.m.

THE SECRETARY: Mr. Chairman, the next submission is that of the Canadian Medical Association known as Exhibit 278 and Dr. Halpenny will introduce his group from the C.M.A.

--- EXHIBIT NO. 278: Submission of the Canadian Medical Association.

SUBMISSION OF THE CANADIAN MEDICAL ASSOCIATION

Appearances: Dr. A.D. Kelly
Mr. B.E. Freamo
Dr. L.R. Rabson
Dr. G.E. Wodehouse
Dr. J.A. McMillan
Dr. T.J. Quintin
Dr. G.W. Halpenny

DR. HALPENNY: Mr. Chairman, Madam Dean and members of the Royal Commission on Health Services: I am Dr. G.W. Halpenny of Montreal and I am President of the Canadian Medical Association.

We appreciate very much this opportunity to present to you our submission and may I introduce to you my colleagues who will speak for the Association.

On my immediate left, Dr. T.J. Quintin of Sherbrooke, who is Chairman of our General Council. Next to him is Dr. J.A. McMillan of Charlottetown, member of the Executive Sub-Committee, Health Services.

The next is Dr. G.E. Wodehouse of Toronto, who is our Honorary Treasurer and is Chairman of our Executive Sub-Committee. I would respectfully request, sir, that questions be addressed to him as he is spokesman

[illegible]



Halpenny

10060

for the group.

Next is Dr. L.R. Rabson of Winnipeg, a member of the Executive Sub-Committee. Mr. B.E. Freamo, our Secretary, Medical Economics of the C.M.A. and next, Dr. A.D. Kelly, the General Secretary of the Association.

I would like to add, sir, that present in the room are representatives of our 10 provincial divisions who have already given submissions to the Royal Commission and I think, sir, this may give you some idea of the importance we attach to our presentations today.

I would now like to ask Dr. Wodehouse to introduce our presentation.

DR. WODEHOUSE: Mr. Chairman, I know that you have encouraged informality. I hope that you will excuse a few of us if we feel inclined to rise to our feet instead of sitting as you have directed other people before you. I would like now to ask Dr. Kelly to read the summary and recommendations.

DR. KELLY: This is the summary and recommendations of our brief which you will find in the yellow pages of the submission before you.

SUMMARY AND RECOMMENDATIONS

Mr. Chairman and Members of the Royal Commission on Health Services:

The request of The Canadian Medical Association appears to have been instrumental in the decision to appoint this Royal Commission on Health Services and we are gratified that such an intensive



Kelly

10061

study of health needs and resources has been undertaken. We entertain high hopes that your labours will be abundantly productive and that your findings will influence the establishment of public policy in matters of health for years to come. We take this opportunity to pay our tribute to the Chairman and Members of this Royal Commission for their unfailing attention to the task at hand. You have caused to be amassed a volume of fact and opinion on health services such as has not previously been duplicated in this country. Your appraisal of the situation will be listened to with respect and you have great responsibilities in framing your recommendations. Your field of interest is so important to Canada that it would be a pity if the momentum gained were permitted to lapse with the filing of your report. We suggest that you might consider recommending a continuing review body to keep current the data which you have collected and to serve as the repository for health information in this country.

The infinite diversity of our health services, the areas where improvements are required, the occasional dark corner and the very large sums of money required to provide quality health services in adequate amount should impress all who have studied it. We have been impressed with the interest of our fellow citizens in all walks of life in promoting improvements in our health services. A great deal of valuable work is being done by a large number of people to promote good health and to mitigate the consequences of disease and disability. These efforts are in most instances voluntary



Kelly

10062

1
2
3 and spontaneous and we detect little evidence of abate-
4 ment in the universal interest in health. In many
5 instances the proper course appears to be to recognize
6 and to endorse the work, in others encouragement and
7 financial assistance will be required while in a few
8 an immediate major effort is indicated. The evolutionary
9 nature of our progressively improving health services
10 is evident and it may be predicted with confidence that
11 barring meddlesome interference the progress will
12 continue.

13 In this submission by The Canadian
14 Medical Association we have endeavoured to avoid unneces-
15 sary duplication of the informative material so amply
16 supplied by our provincial Divisions and by the many
17 other medical organizations which have testified. We
18 have, however, extracted those important considerations
19 and recommendations which have emerged from the briefs
20 of the medical profession at many of the previous hearings
21 and have undertaken to restate them and arrange them in
22 their order of relative priority. We have endeavoured
23 to make constructive comments on the health services
24 which relate closely to the Government of Canada. We
25 have provided some thoughts on the factors which relate
26 to quality in health services and have undertaken to
27 summarize broadly the important areas of mental health
28 services, maternal welfare and rehabilitation. Specific
29 comments are supplied on such diverse topics as occupa-
30 tional health services, workmen's compensation, geriatrics,
accidents, alcoholism, physical education and fitness,
home nursing and the development of alternative care



Kelly

10063

programs and the relationship of smoking to cancer of the lung. In all of this we have endeavoured to relate our comments to your specific terms of reference.

The recommendations of The Canadian Medical Association are presented in the order which we have assigned to their relative priority in importance and in timing. The numerical references are to paragraphs in the narrative.

Our first recommendation relates to I. Personnel, Education and Research and in our view takes priority number one.

Believing that the provision of adequate numbers of trained health workers is the first essential to improvements in health services we recommend:

1) That the career possibilities of medicine and paramedical work be made as attractive as possible and that all efforts at recruitment of well qualified candidates be supported. (11-13, 142-145, 155)

2) That the future requirements for physicians be accepted as a goal to be attained within the next generation, that existing medical schools be aided and encouraged to increase their output of graduates in medicine and that universities not now undertaking the education of physicians and other health workers be encouraged to consider their ability to do so. (142, Appendix A)

3) That financial aid to Canadian



Kelly

10064

universities and their Faculties of
Medicine be provided in the form of
grants from public funds based on the
enrolment of medical undergraduates.

(145)

4) That a revolving loan fund be
established from public and private
contributions to assist individual
medical students to complete their
training. (145)

5) That support of medical research
from Federal sources be increased to
the extent recommended by the Special
Committee Appointed to Review Extramural
Support of Medical Research by the
Government of Canada. (231)

Second priority:

II. Facilities

Emerging from the submissions which
have been placed before this Royal Commission it is
apparent that shortages of institutional facilities
exist in many parts of Canada and that one effect of
universally available hospital insurance has been to
accentuate these deficiencies. We recommend:

6) That a selective building program
for active treatment hospital beds be
pursued in the urban and metropolitan
areas where the need is greatest and
that the hospital construction grant be
amplified to assist this construction.

(10, 78, 156)



Kelly

10065

- 7) That institutional facilities for the care of chronic, convalescent and other long-stay patients be provided in close proximity to active treatment hospitals and that the immediate objective be the provision of 1.5 such beds per thousand of population. (159-161)
- 8) That in the recommended new approach to the care of patients suffering from mental illness, the construction of units of 200 beds or less be proceeded with in relation to selected regional general hospitals. (42, 43, 87)
- 9) That in addition to the construction of the facilities mentioned, programs of alternate care, including home-care and the provision of home nursing and home-maker services be encouraged. (136, 137)
- Third priority:

III. Special Services

Two areas of service to persons requiring special attention emerge as pressing needs in all parts of Canada. We recommend:

- 10) That a complete overhaul of the mental health program be undertaken to provide considerably improved services to the large body of Canadians who suffer from psychiatric disorders. The essential improvements include
- a) the recognition of mental illness



Kelly

10066

as the equivalent of physical illness and the encouragement of the care of the psychiatric patient in his own community. (43, 46, 48)

b) the provision of wings, wards or designated beds in general hospitals for the care of psychiatric patients and the gradual replacement of our large mental hospitals by much smaller institutions closely related to regional general hospitals. (43, 158)

c) the provision of consultative and out-patient's services and special facilities for the care of mentally deficient and mentally retarded children as well as for the care of the senile psychotic. (46)

d) the improvement of the terms of employment in mental health services for workers of all types, in order that personnel shortages may be overcome. (44)

e) that research be encouraged and more adequately subsidized. (47)

Second special facility:

11) That all aspects of the process of rehabilitation be improved by

a) promoting the establishment or extension of rehabilitative services in large general hospitals, in the chronic and convalescent facilities to be



Kelly 10067

provided in conjunction with such hospitals and in institutions for the mentally ill and retarded... (159, 171, 173)

b) fostering the development of independent rehabilitation centres in communities of more than 50,000 and the provision of mobile rehabilitation units as adjuncts. (171, 173)

c) encouraging the training of all types of personnel connected with the process of medical rehabilitation, preferably in Departments of Physical Medicine and Rehabilitation connected with University Faculties of Medicine. (167, 173)

Fourth priority:

IV. Medical Services Insurance

We suggest that this Royal Commission should recognize that the provision of medical services insurance represents only a small portion of adequate health services for Canadians. The development of voluntary forms of coverage is making steady progress and the prospect of the availability of insurance to every Canadian who needs and wants it is in sight.



Kelly

10068

The services of physicians are not withheld from patients in poor economic circumstances and it cannot be maintained that necessary medical care is lacking to any demonstrable degree. We appreciate, however, that the benefits of comprehensive insurance cover should be made available to all Canadians and we recognize two main classes of society who are unable to purchase it completely from their own resources.

We specify and identify these categories as accurately as possible and suggest methods of applying criteria of need to individual applicants. It is our view that only these two categories should be assisted from public funds. We do not subscribe to the introduction of universal, compulsory, tax-supported comprehensive medical services under Government auspices and we feel that public funds should not be applied to the self-supporting in the area of medical insurance. We recommend:

12) That, for the 1,520,000 persons, whom we estimate, or approximately 8% of Canada's population who may be adjudged to be medically indigent, tax funds be used to provide comprehensive medical insurance on a service basis.

13) That a system for the provision of prescribed drugs be instituted for the above mentioned group whose medical services insurance is underwritten from public funds.

14) That for persons in economic circumstances just superior to the identifiable indigent we recommend



Kelly 10069

the application of tax funds on proof of need to permit the partial assistance which they require.

- 15) That approved carriers of medical services insurance be selected from the plans now operating under voluntary auspices or from plans now providing social assistance medical services to provide insurance cover for those persons aided from public funds.

V. Federal Health Services

In our appraisal of the health services which are the direct responsibility of the Federal authority or which are in large measure financed from Federal funds certain improvements are suggested. Our recommendations are set out under the relevant headings.

Health and Welfare of Indians and Eskimos

- 16) We recommend that

- a) all services related to the health and welfare of these groups be administered by a single Department, preferably the Department of National Health and Welfare.
- b) the identification of Indian and Eskimo patients eligible for treatment at the public expense be made more exact.
- c) special efforts be made to reduce maternal and infant mortality among the group we are talking about.



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

Page 108

The utilization of the funds of the
to meet the needs of the social assistance
which they are now,

(b) That approved agencies of the
services should be selected from the
as now operating under voluntary
agencies or from plans now providing
social assistance needed services to
provide insurance cover for these
persons added from public funds.

Federal Health Services

In our appraisal of the health services
which are the direct responsibility of the Federal author-
ity or which are in large measure financed from Federal
funds certain improvements are suggested. Our recommendations
are set out under the relevant headings.

Health and Welfare of Indians and Alaskans

(a) We recommend that

(1) all services related to the health
and welfare of these groups be adminis-
tered by a single department, presently
the Department of National Health and

(2) the health status of Indian and
Alaskan patients should be reported
to the public health service

(c) Special attention should be given
to the health of the Indian and Alaskan
populations.



Kelly 10070

d) the relevant provincial schedule of medical fees be made the basis of payment to private practitioners for services rendered to Indian and Northern Health Services patients.

e) the qualifications of all doctors appointed to the Indian and Northern Health Service be registerable and that terms of service be made more professionally attractive.

National Health Grants

17) We recommend that

a) the hospital construction grant be increased to provide a higher proportion of the cost of new approved hospital beds.

b) that the professional training grant, the mental health grant and the medical rehabilitation grant be increased.

Hospital Insurance and Diagnostic Services Act

18) We recommend legislative amendments to provide

a) that mental hospitals and tuberculosis sanatoria be included in the scope of the Act.

b) that shareable costs be extended to cover the carrying charges of hospitals' capital debt and depreciation on buildings and equipment.

c) that the special position of teaching hospitals be recognized.



Kelly 10071

d) that the arrangements for the financing of departments of radiology and pathology be related to their work loads and, if possible administered by separate funding.

Food and Drugs

19) We recommend that the authority, the staff, the facilities and the budget of the Food and Drug Directorate be amplified to provide for

a) the control of quality, potency and safety of all drugs offered for sale in Canada.

b) an authoritative information service on all new drugs.

c) ways and means to facilitate clinical trials of new pharmaceutical products.

20) With a view to reducing the price of prescribed drugs to the patient we recommend that the Federal sales tax of 11% be eliminated.

Department of Veterans' Affairs

21) It is recommended that the functions of D.V.A. Treatment Services be reassessed to determine whether more effective use of their active treatment facilities may not be possible.

VI. Miscellaneous recommendations

As a consequence of our examination of the health services now being rendered to Canadians a



1944

(1) That the Department for the time being
and of the Department of the Interior and
the Department of the Interior be related to their work
in the Department of the Interior, it is recommended by
the Department of the Interior.

Food and Drug

(1) We recommend that the Department, the staff
the facilities and the budget of the Food
and Drug Administration be unified to pro-
vide for
(2) the control of quality, quantity and
safety of all drugs offered for sale
in Canada.

(3) an administrative information system
on all new drugs.

(4) ways and means to facilitate clinical
trials of new pharmaceutical products.
(5) with a view to reducing the price of re-
spected drugs to the patient we recommend
that the Federal sales tax of 10 per

Department of Veterans Affairs

(1) It is recommended that the functions of
the Department of Veterans Affairs be reassigned
to determine whether more effective use of
their active treatment facilities may not
be possible.

Department of Veterans Affairs

It is recommended that the Department of Veterans Affairs
the health services not being rendered to the public.



Kelly 10072

number of desirable aids to their improvement have become apparent. We do not classify them as specific projects for priority in implementation but rather as areas which should not be overlooked in the progressive improvement.

a) Research in alcoholism, in the medical aspects of rehabilitation and in the prevention of traffic accidents deserves further support than has been afforded.

b) The use of subsidy by public funds to induce the location of a physician in areas otherwise unable to attract a doctor is recommended.

c) The continuing education of Canadian doctors should be further encouraged by the deductibility of the expenses of refresher courses in tax returns.

d) Educational efforts directed towards the prevention of accidents, particularly traffic accidents should be intensified. Appropriate amendments to the Criminal Code to restrain the drinking driver should be supported.

That concludes the summary and recommendations.

THE CHAIRMAN: Do you wish to add anything further at this time, Dr. Halpenny?

DR. HALPENNY: No, sir.

THE CHAIRMAN: Or any one of your associates?



Wodehouse 10073

DR. WODEHOUSE: I think it might be helpful if you had a little bit more knowledge of the people you see before us. You heard us introduced in our various capacities. I think you should recognize that the views that we bring forward to you are the views that the members of our Association have asked us to bring forward, and that we truly speak for the Association in the thoughts that we have put forward to you in this brief.

I might say from a matter of personalities that two of us are surgeons, three of us are physicians, one is an ex-pediatrician and now a very capable and knowledgeable medical administrator, our General Secretary, one is an economist in whom, sir, we have confidence, and who we feel knows as much about this business as anyone in the country. Two of us practise in groups. Three of us practise individually as solo practitioners. Four of us have university affiliations of varying degrees. At least two of us enjoy part-time salaries.

You will remember that in our preliminary letter to the Prime Minister we suggested that we would like a non-political, independent Commission to look into all aspects of health services and needs of the country. In bearing with that we have two card-bearing Liberals in our group. One very active Progressive Conservative. Three whose politics I don't know, but they could conceivably include an N.D.P., but it is improbable. Then you have myself. I would describe myself as a progressively-minded Liberal-Conservative, with a very strong and pronounced sense of social justice.



10074

1
2
3
4 THE CHAIRMAN: Thank you, Dr. Wodehouse.
5 I think I might say for myself that your brief, your
6 submission, is a very complete one, and apart from a few
7 items I think it sets forward your position, and answers
8 many of the questions which have been arising from time
9 to time in the various hearings throughout the ten
10 Provinces that we have now been in. However, we appreciate
11 very much the offer to place yourselves wholly at our
12 disposal in furnishing further information, amplifying
13 your views where you may feel it necessary, and in
14 answering questions, and I think we will start off this
15 morning, I will ask Professor Firestone if he has a few
16 questions to put.

17
18 COMMISSIONER FIRESTONE: Mr. Chairman,
19 Dr. Halpenny, Dr. Wodehouse, and gentlemen: I would like
20 to compliment you, like the Chairman did, on the well-
21 thought-out brief which you have been good enough to
22 submit to us. I observe that in your team before us, and in
23 the Presidents of the Provincial Associations, the main
24 medical associations, you have some of the most competent
25 and knowledgeable members of the medical profession, and
26 I have had the privilege of questioning them in other
27 parts of Canada.

28 I know the C.M.A. is welcoming this
29 opportunity of putting its views forward so that we and
30 the public at large understand what the C.M.A. stands for
on some of the basic issues.

I would hope that you would look at
my questions as an effort on my part to understand your
position fully. If I do not comprehend any points of view



Wodehouse 10075

that you put forward, please explain the situation to me, and correct any misapprehension that I may have in understanding your views.

I may not find all the views you express as convincing as you might feel, but please be assured that I respect the sincerity and the integrity of your views that you will be putting forward.

I shall be putting the questions to you, Dr. Wodehouse, but please feel free to call on your colleagues to deal with any question as you so desire. Would it be convenient, Dr. Wodehouse, if I would commence the questioning with questions relating to the statement of principles which the C.M.A. has introduced on Page 79 of your brief? We might be able to bring up any related points as we discuss the principles. Would that procedure be satisfactory to you?

DR. WODEHOUSE: Quite, sir, however you wish to play it.

COMMISSIONER FIRESTONE: In Paragraph 190 on Page 79, the first principle which the Canadian Medical Association has put forward before us deals with, and I quote: "The highest standard of medical services should be available to every resident of Canada". Could you explain to us what you mean, should be available?

DR. WODEHOUSE: Mr. Chairman, the only limitations on this statement, because we feel that the highest standards of medical care are now available to every resident, the only limitations are ones of geography and personnel. Parts of our country, by geography however, are too far removed from physical facilities, and



that you are, please explain the situation to me, and correct any misunderstanding that I may have in understanding.

I may not find all the views you express as convincing as you might feel, but please be assured that I respect the sincerity and the integrity of your views that you will be setting forward.

I shall be putting the questions to you, Dr. Wodchowski, but please feel free to call or your colleagues to deal with any question as you so desire. Would it be convenient, Dr. Wodchowski, if I would commence the questioning with questions relating to the statement of principles which the C.M.A. has introduced on Page 19 of your brief? We might be able to bring to any related points as we discuss the principles. Would that procedure be satisfactory to you?

Dr. WODCHOWSKI: Yes, sir, however you wish to play it.

Q: On Page 19, the first principle which the Canadian Medical Association has put forward before us deals with, and I quote: "The highest standard of medical services should be available to every resident of Canada." Would you explain to us what you mean, should be available? Dr. WODCHOWSKI: Yes, Chairman, the only limitations on this statement, because we have not the highest standards of medical care are now available to every resident, the only limitations are ones of geography and personnel. Facts of our country, by your report, however, are too far removed from physical conditions, as



Wodehouse 10076

parts of the country in the outlying areas it is very difficult to attract doctors of any kind, because of the difficult living conditions, and the difficulty of making a living. Other than this, we feel that the highest standard of medical care service is available to everyone.

DR. RABSON: In recommendation VI (b) we have asked for the use of subsidy by public funds to induce the location of physicians in outlying areas.

DR. McMILLAN: Is it not the duty of each member of a profession and its organization to attempt to provide the people it serves with the highest quality of the service which they represent?

COMMISSIONER FIRESTONE: Well, if we just can understand how one can translate this availability into practice. I am very happy to hear and have this assurance that this high quality of service is available to pretty much everyone in Canada, with some practical limitations as you outlined.

One of the assignments that the Commission has is to find ways and means of recommending how this availability is translated into action, so that out of the availability comes actual coverage. At least, this is my interpretation. My colleagues may have some other views on the subject, but my question is proceeding on the premise that we are looking for a method of translating availability into an actual program, which in fact will cover the overwhelming majority of Canadians, and therefore the question before us is, how do we translate availability into actual coverage that will cover in fact the majority of Canadians?



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Wodehouse 10077

DR. WODEHOUSE: I will have to interrupt at this point. I have followed Dr. Firestone's questions with interest across the country, and once again he is implying that he thinks these things are not available. I have already said that in my mind they are available, with the exception of geography, personnel and facilities. I cannot accept Dr. Firestone's premise that he has such a problem.

DR. McMILLAN: I explained this in Prince Edward Island, which we consider an outlying part of Canada, and we illustrated how the service of specialties, not available in our Province at all, are available in a very fast and efficient manner by having them referred to other areas by the doctors involved.



When we say they are available, we believe this is so. I said from my own personal experience the person requiring these special services had them available almost as quickly in these outlying areas as if they had been in the metropolitan areas.

COMMISSIONER FIRESTONE: To come back to the points that you made, Dr. Wodehouse, are you suggesting then that except for certain rather limited areas that there is not a need?

DR. WODEHOUSE: I said within limitations of personnel and services.

COMMISSIONER FIRESTONE: I think that is a very fair clarification. I understand that, Dr. Wodehouse. Are we not trying to develop a plan which will cover the provision for health services in Canada for the next ten, and some have suggested twenty, twenty-five years, and presumably in developing such a plan we take account of the requirements of the Canadian people and perhaps plan the provision of personnel and services within such a plan. Therefore can we carry on the questioning, Dr. Wodehouse, in the sense of not the situation as exists at the moment but the situation as we want to develop for the future.

DR. WODEHOUSE: I would be very pleased to do that. Might I remind you, Dr. Firestone, before we go that far we have in our recommendations described what we feel is the plan for the health services of Canada. We recommend this plan in points of priority and in areas of what we believe to be real needs. We have outlined this in keeping with your terms



When we say they are available, we believe this is so
I said from my own personal experience the general
regarding these special services that they would be
almost as quickly in these ordinary areas as it they
had been in the more urban areas.

... To come
back to the points that you made, Mr. Wodchuk, are
you suggesting then that except for certain rather
limited areas that there is not a need?

Mr. Wodchuk: I said within 15 sta-
tions of personnel and services.

... I think that
is a very fair classification. I understand that, Mr.
Wodchuk. Are we not trying to develop a plan which
will cover the provision for health services in Canada
for the next ten, and some have suggested twenty,
thirty-five years, and presumably in developing such
a plan we take account of the requirements of the
Canadian people and perhaps plan the provision of
personnel and services within such a plan. Therefore
can we carry on the questioning, Mr. Wodchuk, in the
sense of not the situation as exists at the moment but
the situation as we want to develop for the future?

Mr. Wodchuk: I would be very
pleased to do that. I think you, Mr. Wodchuk,
before we do that we have in our report and in
discussed what we feel is the plan for the health
services of Canada. We recommend this plan in order to
bring out in areas of what we believe to be the
needs. We have outlined this in keeping with your terms.



Wodehouse

10079

1
2
3
4 of reference with concern to the needs, to recommend
5 the means of filling any deficiencies. Our plan is
6 outlined in our recommendations. The first priority
7 is training various types of personnel; the second one
8 is improvement of facilities; the third one is the
9 improvement of two special services, mental health and
10 rehabilitation services; the fourth one is insurance,
11 the fifth one is federal health services and the last
12 one miscellaneous recommendations.

13 Mr. Chairman, in my mind, in our minds
14 this is the plan for the health needs of this country.
15 It is in this context we talk about the plan. Unfortunately,
16 sir, much emphasis has been given in the hearing of this
17 Commission and elsewhere to medical service insurances.
18 That is a minor part of the health needs of Canada.
19 It has to be considered in full context and with
20 relationship to all other health needs and it should
21 only be considered that way and should only be given
22 that emphasis.

23 COMMISSIONER McCUTCHEON: You say there
24 are a number of things more important?

25 DR. WODEHOUSE: Many more, we believe
26 there are others more important and our recommendations
27 show that.

28 DR. McMILLAN: I think it is only
29 fair any principle, the basic principle of all thinking
30 is that in the 100-odd years that Canadian medicine has
been organized many achievements have results. Our
basic principle and purpose in setting up these principles
was to make use of all that exists and is good at the



Wodehouse

10080

1
2
3
4 present time and to make sure it is going to be good
5 in the future. We are going to use that first of all.
6 That indicates what is left is only a small part of
7 what is to be done.

8 COMMISSIONER FIRESTONE: I would like
9 to congratulate you, Dr. Wodehouse in making such a
10 convincing point in saying that the C.M.A. is really
11 recommending a comprehensive health care program, not
12 just one particular part of it. I think it is a most
13 welcome and constructive statement. It is in that
14 context I would like to question you, sir. As I recall,
15 sir, you mentioned the availability of personnel and
16 facilities are essential to the expansion of services.
17 I think that makes very good sense, sir. In questioning
18 other witnesses we were told in order to develop these
19 increased services and facilities we also need a program
20 which will make these facilities, translate these
21 facilities from brick and mortar and people into
22 services to those that receive medical and other health
23 services. I am just wondering whether this sort of
24 priority you have suggested you want to see, building
25 hospitals and other facilities, whether this should not
26 go hand in hand in the development of the program which
27 will make it possible for the people of Canada to
28 benefit from these services. I want to make it,
29 perhaps, even more difficult for you and to ask you
30 whether speaking in practical terms sometimes it may
not be helpful to develop a program and push the
medical profession and the universities to train more
doctors and train more health personnel.



1922
 10/22/22

present time and to some extent in the future.
 in the future. We are now in the first of all.
 that indicates that is left is only a small part of
 what is to be done.

CONVULSIONS IN THE FUTURE. I would like
 to congratulate you, Dr. Williams, for making such a
 convincing point in saying that the "A" is really
 recommending a comprehensive health care program, not
 just one particular part of it. I think it is a great
 welcome and constructive statement. It is in that
 context I would like to question you, sir. "A" really
 sir, you mentioned the availability of personnel and
 facilities are essential to the expansion of services.
 I think that makes very good sense, sir. In questioning
 other witnesses we have said in order to develop these
 increased services and facilities we also need a program
 which will take these facilities, personnel, money
 facilities from brick and mortar and people who
 services to areas that need, we medical and dental health
 services. I am just wondering whether this part of
 which you have suggested you want to see, building
 hospitals and other facilities, which this should be
 so hard in fact in the development of the program which
 will make it possible for the people of Canada to
 benefit from these services. I want to make it
 simple, even more difficult for you to say we
 would be speaking in a technical terms. I mean
 not be related to having a program and then the
 the first question and the answer is that we
 would be losing more health personnel.



Wodehouse

10081

1
2
3
4 DR. WODEHOUSE: I have to take exception
5 again, to Dr. Firestone's preamble. We said we are
6 willing to advance on a number of fronts. We accept
7 the building program initiated by the Federal health
8 grants and the grants of the provinces have been
9 helpful. We accept the various other health grants have
10 been helpful. We also accept for 35 years we have been
11 promoting this idea of medical service insurance. For
12 anyone at this moment to say it is a brand new concept
13 that has to be shoved or pressed upon the doctors for
14 the good of the people, then, Mr. Chairman, that with
15 due respect is malarky. It is our business. We have
16 been doing it. About 60% of the population in Canada
17 has some degree of coverage. We anticipate that within
18 ten years that will go to 70%. It is right to say
19 the hard core of indigent and low income persons need
20 help. We have a successful, practical, economic,
21 dignified method of helping those persons. Again it
22 is a wrong premise that this Government or this
23 Commission or the politicians or the press have to
24 press us into doing something we have been doing already
25 for such a long period. What we would like is the
26 privilege of continuing in this evolutionary process,
27 of bringing progress in all fronts and bringing it
28 under our own auspices because, Mr. Chairman, we feel
29 we know a lot about these things. We feel we know a
30 lot more about it than most of the lay people who are
indulging in, what we call, meddlesome interference.

THE CHAIRMAN: That clause, of course,
does not include the Commission.



Wodehouse

10082

1
2
3
4 DR. RABSON: Mr. Chairman, I would
5 think Dr. Wodehouse's statement calls for a little
6 further in answer to Dr. Firestone's question. As
7 Dr. Wodehouse said this evolutionary process -- we think
8 it is dangerous for anyone to make specific plans for
9 a project of which no one knows the answer. We don't
10 think anybody in the world knows the proper way to
11 administer health care in its comprehensive sense, and
12 particularly medical care. This is something that is
13 a problem. We have found these deficiencies and we
14 recommend this be done first. We may then find other
15 methods of approaching this. Certainly our experience
16 of providing medical service insurance, we have made
17 many errors which, by experiments, have come to light.
18 For someone to say they have the total answer to this
19 problem, -- we don't think it exists. We feel it is
20 an evolutionary process.

21 THE CHAIRMAN: Since Dr. Wodehouse
22 has appeared to make some form of appeal to me may I
23 put it this way, that we appreciate that you have come
24 forward with an overall development for the future and
25 so forth and have given a great deal of thought and
26 consideration, but I don't think we can at this moment
27 assume merely because you have come forward, the Canadian
28 Medical Association put forward a plan that it must
29 necessarily be the only road to the future in that
30 respect. I mean to say that the views put forward are
entitled to a great deal of respect, but the question,
the whole question remains unanswered, at least as far
as the Commission is concerned until we discharge
ourselves after having made this report. I think this



Wodehouse

10083

discussion here today will be fruitful, even if it may be a little irritating or annoying to you gentlemen. It is, I suppose, one of the things you are going to have to submit to because, I suppose, the way which you defend your principles and position may point up just how sound or unsound the position you are taking actually is.

DR. WODEHOUSE: Thank you very much for those remarks. I didn't mean to imply any criticism, sir, to the question. We welcome all the questions and will be here as long as you wish. I am objecting to the impression that some of your Commissioners leave in their preambles to their questions. That is my objection.

COMMISSIONER McCUTCHEON: You would prefer questions and not speeches?

DR. WODEHOUSE: I would.

DR. McMILLAN: There have been many occasions I have differed with my confreres. This may be one of them. I am a little more sympathetic to Dr. Firestone's approach to these questions than my confreres. I would think Dr. Firestone is trying to get from us.....

THE CHAIRMAN: We are not going to have any discussion about Professor Firestone. That is number one. Number two is the questioner is entitled to put the question in the form as he wishes it, otherwise, it simply permitting someone to edit the question which must not be permitted. My friend, Mr. McCutcheon and I from our training, perhaps, find it a little easier to put short questions because we have learned from long years

320.18.04



Wodehouse

10084

1
2
3
4 of experience that it is the short question that will
5 bring intelligible answers. We all have our own methods
6 of doing these things.

7 DR. WODEHOUSE: Professor Firestone's
8 putting of his questions is perfectly acceptable. I
9 would like the privilege of correcting any preamble
10 which may be out of context with the actual question.

11 THE CHAIRMAN: There will be no
12 limitations on the right to make statements or to deal
13 with the questions as you wish. Naturally both the
14 questions and the reply must have some relevancy to
15 what we are doing here.

16 COMMISSIONER FIRESTONE: Thank you Mr.
17 Chairman. As I said at the beginning, Dr. Wodehouse,
18 I was hoping you and your associates would feel free
19 to comment and put my thinking straight at any stage,
20 and I have invited this sort of approach. I didn't
21 anticipate you would be using a term like "malarky",
22 but that, of course, is your own good judgment.

23 I think, Dr. Rabson, you really dealt
24 with my question that I put to Dr. Wodehouse. I have
25 asked the question whether one first creates additional
26 manpower and supplies and facilities and then provides
27 arrangements for making it possible for an economic
28 filling use of such facilities, or whether one might
29 develop a program and as a result of the program
30 encourage the building of additional facilities,
training of additional doctors, nurses, internists
and other personnel. As I had visualized the development
of the national health program for Canada, please correct



of existence and it is the sort of question that will
 being intelligible answers. We all have our own problems
 of being there to them

bottom of his answer is a positively acceptable. I
 we will like the idea of correcting any pressure
 which may be out of contact with the actual question.

But that's the point: there will be no
 limitation on the right to use statistics in the field
 with the questions as you wish. Naturally both the
 questions and the answers must have some relevance to
 what we are doing here.

With respect to the other point, thank you Mr.
 Chairman. As I said at the beginning, Mr. Johnson,
 I was hoping you and your associates would feel free
 to comment and let my criticism stand at my state,
 and I have invited this sort of approach. I didn't
 anticipate you would be using a term like 'industrial',
 but that, of course, is your own good judgment

I think, Mr. Johnson, you really resist
 with my question that I put to Mr. Johnson. I have
 asked the question whether one should consider such things
 important and significant and whether they provide
 answers which for reasons at present for an economist's
 study use of such facilities, or whether one might
 develop a program and as a result of the program
 extend the balance of shift and facilities,
 training of additional workers, changes, industrial
 and other personnel, as I had visualized the situation
 of the national health program for Canada, please



Wodehouse

10085

1
2
3
4 me if my appreciation is not quite the right one in
5 your opinion, was that one would proceed in developing
6 the program, both in providing the services and
7 financial ways and means of training the personnel and
8 providing facilities; in other words the program would
9 proceed along a number of fronts at the same time and
10 not have a priority, one, two, three. Is this approach
11 acceptable to you and your colleagues or have you
12 another one?

13 DR. RABSON: I think there is a great
14 danger in developing a program before you have personnel
15 and facilities. I think that history has shown that if
16 you do that, particularly in a professional field you
17 tend to lower the standards in order to procure enough
18 professionals to fill your needs. I think that is
19 your great difficulty.

20 -

21 -

22 -

me if in operation is not airtight the right one in
 your opinion. I think one would proceed in developing
 the program, both in the services and
 financial ways and more of train of the personnel and
 provide facilities; in other words the program would
 proceed along a number of fronts at the same time and
 not give a priority, one, two, three. Is this approach
 acceptable to you and your colleagues or have you
 another view?

MR. KILPATRICK: I think there is a great
 danger in developing a program before you have personnel
 and facilities. I think that history has shown that if
 you do that, particularly in a professional field you
 tend to lower the standards in order to procure enough
 professionals to fill your needs. I think that is
 your great danger.



Rabson

10086

I think this has been done, sir, definitely, so that I would think there is great danger in developing a program before you have the professional personnel facilities. I think certainly this is why our number one priority has been given to this project, this terrific danger of lowering standards in order to find sufficient personnel, and I think, as I say, this has been illustrated in more than one field.

COMMISSIONER FIRESTONE: Would you say, Dr. Rabson, that this lowering of standards that you speak of - I don't quite see it. You introduce a program and you have only got so many doctors, but I mean if one plans a program over a long period of time will there not be a time where we are all short of something or other, and this may affect quality. We may develop the services as well as the personnel, and the facilities concurrently?

DR. RABSON: Yes.

DR. WODEHOUSE: I think I have already said this. If you develop a program of mental health care and you have not the psychiatrists in order to provide the care all the facilities across the country will not help. I think the programs have to go forward concurrently, Mr. Chairman.

COMMISSIONER FIRESTONE: This concurrence involves the ratio of products or service. In other words, making it possible for more people to acquire such service. Is that included under that category?

DR. WODEHOUSE: I go back to the instance that I have quoted; psychiatrists in mental health



Wodehouse

10087

services. If you don't have the psychiatrists for the mental health service, no matter what kind of a plan you have it doesn't make it available to the people.

COMMISSIONER FIRESTONE: Can we still develop this a little bit further? Would you include, for example, providing financial arrangements for people to acquire medical care service who cannot pay for such service at the present time?

DR. WODEHOUSE: Mr. Chairman, such facilities are available to most Canadians. Now, the actual facilities available to all Canadians, regardless of their ability to pay, but apparently it's the wish of government and I commend them on that, they wish to contribute a little bit more to those persons who are unable to pay.

As far as the people who are completely indigent are concerned, I have said this before but I think it should be written in the record; there are six plans operating in six provinces which presently provide service to the indigent person. That is indigent as classified by welfare needs. The Blind Craft, Mother's Allowance, the Old-Age Pensions and so on.

In Ontario, excuse me if I speak occasionally of my own province of which I am more familiar; Ontario is fairly typical of the feeling in the other five provinces. This has been operating under the auspices of the Ontario Medical Association since 1935. It is a co-operative effort between the Association and government.

Government provides the per capita payment



Wodehouse

10088

per month on welfare health. The money is given to the Association to administer and the Association provides it to those participating members on a fee-for-service equitable basis. This is 50% contribution of cost on the part of government and about 50% contribution of service on the part of the profession.

In our mind this is an excellent example of government entrusting the money to trustworthy people to administer on their behalf. In connection again, sir, with the other four provinces, that is the practice across the country. It is the same trust. This is an excellent example, as I say, of government giving the money to people who know their business.

Any time government funds are involved, a government agency can administer it. In the Ontario welfare plan, naturally, there are audited statements, financial reports, that go forward to the Government. There is a Committee set up whereby the provinces can work out any difficulties or where any criticisms can be directed. To my knowledge, there has been no such criticism in the 35 years, 30 of the 35 years.

In the matter of expenses, which are a little bit heartbreaking sometimes, they can go on for two or three years over a matter of ten or fifteen cents increase per month. Nevertheless, they are acceptable to this particular group. We recognize that there is a small - not a small group, but a reasonably-sized group who are the true indigents who are so pressed for money they need partial assistance in many areas. They need it in their food, in their fuel, in their clothing, in their housing. They are just getting by and the last on



Wodehouse

10089

the list traditionally in this and other countries is, of course, the payment of their doctor bills and this is an acceptable situation to us. We accept it. If they can't pay it there is no pressure put on them to pay it. If they want to pay it over a long period of time, they have that privilege.

Mr. Chairman, we put forward a recommendation here of partial assistance to these persons who are in financial need and who want to develop some means of paying their doctor and we recognize that this is an answer to the pressure from other people. It is not brought forward necessarily by ourselves. We are not insisting on being paid by everyone but if other people are insisting on our being paid, then this is one way we think it should be done. That constitutes, Mr. Chairman, approximately 22% of the population, the people who need either total or partial assistance.

We feel that the remainder of the population should be encouraged to develop their own medical service insurance, or pay for it, which many people like to do, and quite a few people, at least, a small percentage of the total population, are able to do.

It is their wish to do that. They should have the privilege of doing it. If it is their wish to buy any of the varying types of insurance, that again should be their privilege. If they want to buy the so-called service insurance, this is their choice, that is fine. If they want to buy the so-called indemnity insurance, that is all right. If they want to buy the so-called major medical, catastrophic illness, that is



Wodehouse

10090

all right.

If they want to buy no insurance at all, it is acceptable.

Mr. Firestone, in many other areas it has been brought out we were going to spread the cost of these who cannot afford to pay for this. Mr. Chairman, we have suggested that this lower income group is the true indigent and marginal income groups receive assistance from taxes.

We feel that we should make voluntary insurance available to them. Mr. Chairman, at the moment, we have some 60% of the population with these facilities. We anticipate on a voluntary basis it will be 70% in another ten years. That only leaves 8% left over without taking into account the 22%, for whom we have recommended assistance for that 8%. We know that 3% won't buy it anyway, don't need it, don't want it. This leaves a very small margin of people who really worry about it as far as insurance is concerned.

Mr. Chairman, I point out, the people do not have to have the insurance. This is an individual choice. There are some people who prefer not to.

DR. McMILLAN: May I just make one remark? The question as to whether or not planning will promote the development of facilities and services, and the availability of services is a question which is very important in the questioner's mind. In a general sense we feel that planning will not promote more availability of service but with the development of personnel ---



and people.

It may seem to you to be impossible at all.

It is possible.

It is possible, in many cases, to

have been brought out and have been going to a head the cost of these who cannot afford to pay for this. The Office has, we have suggested that the lower income group is the more indigent and marginal in the groups receiving assistance from taxes.

We feel that we should make voluntary

insurance available to them. Mr. Chairman, at the moment we have some of the legislation with these facilities.

We anticipate on a voluntary basis it will be the

another ten years. That only leaves 88 left over without taking into account the 50, for whom we have recommended

assistance for that 50. We know that 50 would pay it

anyway, don't need it, don't want it, this leaves a

very small margin for those who really want it, but it

is not as difficult as it seems.

Mr. Chairman, I bring out, the people

do not have to have the Government. This is an individual

matter. There are some people who would not do

Dr. Williams. May I just make one

remark. The question as to whether or not something

will be more the development of facilities and services

and the availability of services to a group of which is

and the extent to which we can do it, it is a general

one we have been talking about for some time now

availability of services but with the development of



McMillan

10091

THE CHAIRMAN: Surely you don't suggest it should just grow up haphazardly?

DR. McMILLAN: No, we do not mean that but that nature of this will not necessarily do this. We feel that the development of the facilities will develop the availability of the service to the population after the priority that we have, and the risk we see. That is because of the fact that the development of standards of service, we feel, is the business of the medical profession and the developing of planning must be our business or, in our opinion, there is a danger that those who plan may try to control the developing of the service.

DR. RABSON: Mr. Chairman, I think you misunderstood Dr. McMillan's remarks. If we did not think planning was necessary, we would hardly have asked for this Commission to investigate the area. We would like to point out, or try to see, the deficiencies in the system that exists and try to control those but these things change so rapidly, that an overall plan, an overall plan put in by government has a tendency to be permanent because they have such political appeal in most cases. This is the sort of thing that we feel the planning is dangerous in. We do feel there is a great need and we have asked, in our submission, we have asked for a definition or estimate, or reviewing body for the same purpose exactly. An overall plan in medical care, we feel, is unwise.

COMMISSIONER FIRESTONE: On the question of planning, we have had some suggestions put forward to the Commission that Canada establish a



Wodehouse

10092

1
2
3 National Health Planning Commission plus encouragement
4 of 10 Provincial Health Planning Commissions. I under-
5 stood the proposal, which was designed to develop
6 programs which will meet the needs, the health needs of
7 the Canadian population for many years to come, not in a
8 static fashion, but a plan that will help us in setting
9 targets in consultation with all the health professional
10 groups; the medical profession is important. Therefore,
11 my question is: is that sort of planning in line with
12 your own thinking?

13 DR. WODEHOUSE: On the first page in
14 our summary and recommendations we pay tribute to the
15 meaning of this Commission. We have said that you
16 might consider recommending a continuing review body to
17 keep current the data which you have collected and to
18 serve as the repository for health information in this
19 country.

20 Now, whether this should be a Planning
21 Commission; whether it should be a Royal Commission such
22 as yourself, appointed periodically at five-year or ten-
23 year intervals, I wouldn't know, but we are in favour of
24 an impartial body looking at the needs and certainly
25 recommending methods of correcting the deficiencies.

26 COMMISSIONER FIRESTONE: Well, if I
27 understood your comment correctly, Dr. Wodehouse; please
28 correct me if I did not: this goes a little further.
29 It covers not only collecting data and preparing an ana-
30 lysis of the data, but formulating views as to what one
can do to make most effective use of the health resources
of the country and especially gaps and how to fill those



Wodehouse

10093

gaps so it would be, in addition to a review of statistics, an advisory function that have to make decisions, whether those decisions are made by the medical profession or by government. Would you go that far, sir?

DR. WODEHOUSE: In our rough thinking, yes. In detail I would have to wait until I see the actual mechanics. At the moment we have three groups across Canada, one being the Minister of Health, the Deputy Minister Administrator, and the third, I think it's the Deputy Minister of Health, to deal with, for example, hospitalization programs.

We have been a little bit disappointed that in spite of our recommending representation on the last Committee, this is a National Committee, we have never been granted access or representation on that Committee. Now, if some Health Advisory Commission is to be developed, sir, we would feel very much sleighted if we were not very much included in the planning and composition of that body.

COMMISSIONER FIRESTONE: I take it from what you say, (a) you endorse the principle and, (b) you wish to participate in it and, (c) you want to participate not only in the Commission but also in the framing of its terms of reference and the economics of it?

DR. WODEHOUSE: That is correct, sir.

COMMISSIONER FIRESTONE: Is that a fair assessment of your view?

DR. WODEHOUSE: May I refer you to our statement of policy which I would think you will see on - I refer you to paragraph, or section, 12. We say there we will participate providing that "the composite



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Wodehouse 10094

opinion of the appropriate body of the medical profession is considered and the medical profession adequately represented on any Board, Commission or Agency set up to plan, to establish policy or to direct administration for any medical services insurance program." This could apply to the Board that you have considered, sir, just as well in this context.

COMMISSIONER FIRESTONE: As I understand, Dr. Wodehouse, this was a proposal made to the Commission. We are grateful to you for giving us the views of the C.M.A. on this proposal so the Commission can consider it.

Referring to your earlier reply, the question of how a comprehensive health care program can be financed, and the various sources of financing. I would like to refer to your No. 2 of paragraph 190.



Wodehouse 10095

There you say that you are in favour of, and I quote: "Insurance to prepay the costs of medical services should be available to all regardless of age, state of health or financial status". Do I understand from this principle, Dr. Wodehouse, that the C.M.A. endorses the principle of prepayment?

DR. WODEHOUSE: Yes, sir. We have been on record since 1949 in favour of the principle of prepayment, and the availability of insurance. We have actually been on record without having commendation, but through our activities in developing this plan for many years prior to that we think that this prepayment plan is good for most people, not necessarily all people.

COMMISSIONER FIRESTONE: And would you extend that principle of prepayment to other health services, outside medical care?

DR. WODEHOUSE: We have concerned ourselves primarily in this statement of policy on medical insurance which relates in our minds to doctors' services. Certainly it can extend to other health services as well. The two Provinces which have not developed their own plan know it is available within their Provinces, and these are the so-called major medical type of things, which cover nurses, doctors, drugs, etcetera, in varying degrees.

COMMISSIONER FIRESTONE: You say too that insurance for the prepaid cost of medical services should be available to all regardless of age. What is the present system of making the prepaid arrangement available on the basis which you have recommended, the private voluntary basis, to people of 65 years and over?



Wodehouse 10096

DR. WODEHOUSE: In most of our plans if a person is a participating member of a group, for example I will go back to P.S.I. again, which is Ontario and the one which I am most familiar with. If a person is a member of that plan and reaches the retirement age, whether 65 or 70, he has the privilege of continuing the insurance, so that more and more people, provided this policy becomes more and more effective across the country, will have the privilege of continuing their insurance on an individual basis. Many employer groups have continued payments on behalf of their retired employees, and this will cover many of the older groups as time goes by.

We have opened up in one of our plans unrestricted coverage in regard to age. We have in Windsor opportunities for individuals to enrol to the age of 70. We have reduced the size of our groups to three or less in many instances. We have adopted methods of community enrolment, four in Ontario and three in Quebec are going on today.

COMMISSIONER McCUTCHEON: You meant to say three or more? You said three or less.

DR. WODEHOUSE: Yes, three or more, and we have had these into enrolment in Ontario throughout the Spring, and we have two in Montreal and the City of Quebec, where the plans are thrown open to any member of that City who wishes to enrol during a three-week period when the enrolment is open. These are what we call evolution. They are methods we couldn't possibly try twenty years ago, when we were in competition with other



Wodehouse 10097

carriers, and had to watch our dollars the same as everyone else. These are the evolutionary approaches to your question.

DR. RABSON: I should say here, sir, that Manitoba takes anybody, regardless of age.

COMMISSIONER FIRESTONE: There are in Canada over a million and a half people in this age group. The exact figure is not available until the results of the 1961 census become available. Would you say there are a considerable number of people in this age group covered in the plans which you have just enumerated? Have you any knowledge?

DR. WODEHOUSE: No, I have no specific knowledge of the numbers. I would say the number is increasing, and increasing rapidly.

DR. RABSON: I think at the end of 1961 there were 142,300 over age 65 covered in our plans. Another thing you should remember is that in the indigent groups covered in the Province, the largest percentage is 65 and over, and their coverage is carried on in that way.

COMMISSIONER FIRESTONE: You probably are familiar that most people in the 65 and over group are mostly people with rather low incomes. We don't have a survey in Canada as yet as to the income position of people in that age group, but there is such a survey published in the book by Herman M. Somers, called Doctors, Patients & Health Insurance, and Anne R. Somers and if I may quote from Page 471 of the experience in the United States, I hope that we will get similar information from our research staff at



Wodehouse 10098

a later time.

Would it be acceptable if I put the information before you, so that we can have a discussion of the principle, subject to verification of the data in the light of the Canadian experience as found by our research staff?

DR. WODEHOUSE: That is quite acceptable.

COMMISSIONER FIRESTONE: This survey suggests, and I may say this survey was taken in 1957, and therefore there would be some improvement in the income position over the last five years, but still it points out the difficulties of the people in this age group. It shows that almost three-fifths of the aged not in institutions had less than \$1,000.00 in total money income, and I think I stand corrected when I said the survey was taken in 1957, because I see the book says the figures relate to 1958. So I repeat again, almost three-fifths of the aged not in institutions had an income of a thousand dollars or less.

In the same study figures are quoted of what it costs for people to obtain medical care insurance in the age group 65 and over. If they have not belonged to a group covered before they joined the group, and there apparently are a lot of people in that position, that cannot obtain coverage, they are now over 65, and not all people are as favourably placed as the people in Manitoba. Well, this calculation showed that it would cost a minimum premium of \$223.00 to be enrolled in a non-profit plan, and up to \$315.00 for plans carried by



October 1951

Dear Sirs

It is a pleasure to put the information before you, so that we can have a discussion of the results, and the verification of the data in the light of the American experience as found in our research efforts.

Very truly yours,
J. W. Williams

cc: [illegible]

Enclosed for the Bureau is a copy of the report, and I may say this copy was taken in 1951, and therefore there would be some improvement in the income tax for over the last five years, but still the points out the difficulties of the people in this age group. It shows that about three-fifths of the age group in institutions had less than \$1,000.00 in total money income, and I think I stand correct when I said the survey was done in 1951, because I am the book says the figures are for 1951, but I must have, of course, the figures of the aged are in institutions and in income of a thousand dollars or less.

In the same study, figures are given of what it costs for people to obtain medical care, especially in the age group 65 and over. If they have not received a medical care, they may be in a bad way. However, the 50 of people in the institution, that is, for other surveys, they are not over 65, and not all people are in the same way. In the case of the aged, this is a situation which is not in the same way. The figures are for 1951, and I must have, of course, the figures of the aged are in institutions and in income of a thousand dollars or less.



Wodehouse 10099

commercial carriers.

Now, these amounts are something between 25 to 30% of the income of the people in that category. Now, there may be, and again this is subject to verification by our research staff, another 30% of the people that have an income, aged 65 and over, of a thousand to three thousand dollars. Well, if they were to try to obtain coverage then they have to pay as much as 10% of their income, or possibly even a little more, or a little less, for these premiums, and I don't have to tell you this is not an easy thing to achieve.

COMMISSIONER McCUTCHEON: At that age though, there are a lot of other things they don't spend money on.

COMMISSIONER FIRESTONE: Well, to deal with the problem of the aged phase, rather than the things that my fellow Commissioner has in mind, as I see it, sir, there are significant problems for the aged population to obtain this coverage through regular non-profit plans, or commercial carriers.

Now mind you, sir, this is in the United States, and we will want to verify whether it is true in Canada, but assuming that our research efforts verify this, how do we come to grips with this problem?

DR. WODEHOUSE: I don't think there is too much difference between the over 65's and the under 65's regarding income. Our proposals are applicable to persons of all ages. We have said that for those qualified for total assistance they should be assisted in the coverage. Those in restricted incomes, who receive



Wodehouse 10100

partial assistance, I think this will cover most of the statistics Dr. Firestone brought out.

We have said also that it should be provided through the carriers presently approved in the various provinces for this group of Government-supported persons. This varies from Province to Province. In Manitoba the Government contributes towards the cost of medical services for their indigents through their Manitoba Medical Services Insurance Plan. In Ontario we do it through the Medical Welfare Plan, which is administered separately from our voluntary plans, but in general on the same principle and basis, and this is the type of thing that we feel should be extended. In Ontario possibly the Ontario Medical Welfare Plan should be extended to cover more people. In Manitoba they are all covered now through the voluntary plan.

COMMISSIONER BALTZAN: Dr. Rabson, will you repeat the figures you just quoted?

DR. RABSON: Our analysis shows that 10% of the population of Canada ----

COMMISSIONER BALTZAN: Would you mind confining yourself to just your province.

DR. RABSON: In Manitoba there are 23,000-some-odd over 65's who are covered under plans. I would like to say this regarding the age 65, and preface my remarks, that any comparisons between the attitude of Canadian and American doctors is entirely unacceptable to us.

I would like to say that we have tried to come to grips with this problem, and as you know, and



Rabson 10101

I am sure you do know, that insuring people over 65 costs a good deal more than insuring people under 65. You may hear other opinions from other medical organizations, but we have asked our Divisions whether or not there should be a special high rate for over 65's, and all of our Divisions have said that they would prefer that the over 65's be enrolled at the same rate as set for everybody else.

Secondly, we have asked all our doctors, in a questionnaire two years ago, whether or not they would be prepared to subsidize the aged group, the chronically ill, the uninsurables, as well as the indigents, and they overwhelmingly answered yes.

The doctors provide at least 50% of the subsidy, and I think as a profession we have the right to be able to subsidize these programs. We feel that in those areas where insuring people over 65 becomes a problem, the doctors play a prominent part in it, but there is no intention on the part of our doctor-sponsored plans, as far as I know, to exclude the 65's and over. We are gradually getting to the stage where we are accepting them in toto for comprehensive care.

The Manitoba figure is 23,800 people over 65. There are 10.4% of the population of Canada over 65, and in our prepaid plans alone 3.2% are insured.

COMMISSIONER FIRESTONE: What was the Canadian total now?

DR. RABSON: That was the Canadian total, 142,308.

THE CHAIRMAN: Over 65?



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Rabson 10102

DR. RABSON: Over 65.

COMMISSIONER FIRESTONE: There are
142,000 people over 65?

THE CHAIRMAN: I don't accept that at
all.

DR. RABSON: These are people enrolled
for insurance purposes.

DR. McMILLAN: These are the people
under individual contracts in the prepaid plans, and not
under groups.

THE CHAIRMAN: The question merely
was, how many of us are over 65 in Canada?

DR. RABSON: 10.4 of the population.

THE CHAIRMAN: That is about 1,800,000.

COMMISSIONER FIRESTONE: How many of
those are insured?

DR. RABSON: We were giving you the
individual enrolment figure.

COMMISSIONER FIRESTONE: You mean the
142,000 are covered?

DR. McMILLAN: By individual enrolment
that is. We do not break down the group enrolment by
ages, because it is the same rate. It is a comprehensive
rate for people, irrespective of ages.

DR. RABSON: And in our municipal
enrolments we do not break it down as to age either.

COMMISSIONER FIRESTONE: You don't
know how many people are insured of 65 and over?

DR. WODEHOUSE: I am sorry, you are
getting into a table of statistics which we did not come



1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Wodehouse 10103

prepared for, but this one statistic is the total enrol-
ment of persons aged 65 and over in plans as of December
the 31st, 1961. This refers only to T.C.M.P. 142,380
enrolled, which constitutes 3.2% of all the persons over
65, and we recognize that 10.4% of the total Canadian
population is over 65.



Report of

Investigation of the activities of the total group
of persons known as and known in plain as of December
the first, 1961. This refers only to "C.M.P. 102, 103
included, which constituted 1.7% of all the persons over
25, and we recognized that 10.4% of the total Canadian
population is over 25.

11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100



Wodehouse 10104

And now, Mr. Chairman, I point out again in order to make more people, at least an equivalent number are enrolled in our other welfare plans or covered by other means that I am sure some of the commercial carriers also have persons. This is 3.2% uses only to those persons we cover ourselves.

COMMISSIONER McCUTCHEON: And only those persons you cover on individual contract.

DR. WODEHOUSE: I do not think that, that is not the way the history reads.

COMMISSIONER McCUTCHEON: But Dr. McMillan says.

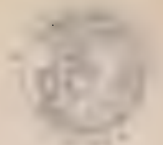
DR. McMILLAN: I was giving these figures from individual plans, most plans do not have the mechanism for breaking down the figures and they represent the individual enrolment groups. These are estimates and the figures I do not think have any value to you without a proper analysis.

COMMISSIONER FIRESTONE: Well, we are coming to you a little later for some help to try and establish whether there is a large number of people covered at present in the group 65 and over or not.

THE CHAIRMAN: I think we can accept there is a very small area covered in that.

COMMISSIONER FIRESTONE: Can we go on the premise there is a small proportion covered without at this stage getting involved in statistics which need further examination?

DR. WODEHOUSE: I do not want to be difficult, but I think 3.2 out of 10.4 is approximately



100-100000

And now, Mr. Chairman, I point out again in order to make it clear, at least an equivalent number are included in the other welfare plans or covered by other means that I am sure some of the commercial concerns also have persons, that is, 10% and only to those persons in other concerns.

It is necessary for an individual to have that is not the way the history books.

Mr. Chairman, I am giving these figures from individual plans, that plans do not have the mechanism for passing down the figures and they represent the individual concern's gross. These are estimates and the figures I do not think have any value to you without a proper analysis.

THE CHAIRMAN: Well, we are going to give a little later on some help to you and we shall see what is a larger number of people covered as appears in the figures and over the year.

THE CHAIRMAN: I think we can do that in a very small area covered in that.

COMMISSIONER: I think we can do that in a very small area covered in that.

THE CHAIRMAN: I am sure to be that is not the way the history books.



Wodehouse 10105

two-thirds which is not too little considering there are other means of coverage also.

COMMISSIONER FIRESTONE: Well, I do not understand the arithmetic. As I understand it 1.8 million, there were 1.8 million people in the age group 65 and over and you mentioned 142,000 covered and I worked this out to 8%; is that correct? Please correct me if I am wrong.

MR. FREAMO: You are quite right, the figures used on percentage were not principals of age 65 and I think we can accept there is a rather small proportion, we think it is increasing every year but it is still a small proportion of the over 65.

DR. WODEHOUSE: I think we should say enrolment for over 65 has only taken place in the last few years and we have found it possible because the numbers are increasing.

COMMISSIONER VAN WART: The Maritime Medical Association has a senior group plan, how many members are enrolled in that, do you know?

DR. BECKWITH: Approximately 8,000 and the charge is \$1.85 a month.

COMMISSIONER FIRESTONE: Now, if I may proceed. It is a significant proportion and I am sure we can come up with higher degree if we get more figures from commercial carriers but if we go on the premise this is less than 20%, there is still a problem that Canada faces. It is true that our research services will show that 90% of the population of 65 and over are earning



Two-thirds of the total is not for little children there
and the other third is for the aged.

Q. Now, I am going to ask you a question.

A. Yes, I am. I am not sure, but I think it is
possible, there are 1.5 million people in the age group
65 and over and you mentioned 1,000,000 covered and I worked
this out to 44, so that is correct. Please correct me if
I am wrong.

Q. Now, I am going to ask you a question.

A. Yes, I am. I am not sure, but I think it is
possible, there are 1.5 million people in the age group
65 and over and you mentioned 1,000,000 covered and I worked
this out to 44, so that is correct. Please correct me if
I am wrong.

Q. Now, I am going to ask you a question.

A. Yes, I am. I am not sure, but I think it is
possible, there are 1.5 million people in the age group
65 and over and you mentioned 1,000,000 covered and I worked
this out to 44, so that is correct. Please correct me if
I am wrong.

Q. Now, I am going to ask you a question.

A. Yes, I am. I am not sure, but I think it is
possible, there are 1.5 million people in the age group
65 and over and you mentioned 1,000,000 covered and I worked
this out to 44, so that is correct. Please correct me if
I am wrong.

Q. Now, I am going to ask you a question.

A. Yes, I am. I am not sure, but I think it is
possible, there are 1.5 million people in the age group
65 and over and you mentioned 1,000,000 covered and I worked
this out to 44, so that is correct. Please correct me if
I am wrong.



Wodehouse 10106

\$3,000.00 a year or less per capita. It is the problem of how to bridge the gap from 20% to 90% and the question I am posing to you is, are you visualizing that the bridge of the gap, in approximate terms, should be achieved in two ways, one through the process of evolution and further expansion of people from group and individual coverage, and, secondly, from a Government payment of the cost of service for people in that age group?

DR. WODEHOUSE: Yes, sir, I think roughly it is true, I take your second statement and refer it back to my general statement that those with low incomes should receive assistance according to their needs.

COMMISSIONER FIRESTONE: How would the Government or the State pay for such medical services, medical care services for people in that category?

DR. WODEHOUSE: This brings us back to our general method of determination who should derive the benefits other than those two groups we have laid out. The first group is clear-cut, the persons receiving total welfare assistance at present. We recognize here that there are four provinces that do not have such plans and we think these four provinces should be encouraged to develop a plan for the truly indigent. We recognize that one of the six provinces we have mentioned has very limited aid, only to the blind and mothers' allowance and it does not cover these other groups. That plan should be expanded to those persons getting welfare needs which are necessary across the country generally along with some supervision, of course.



...of the ... is the ...
 ... from 1911 to 1912 and the question
 ... that the
 ... should be
 ... through the process of ...
 ... and further ... and individual

... of service for people in that age group.
 ...
 ... I take your second statement and
 ... that of the
 ... according to their

... would
 ... the Government of the State pay for such medical services,
 ... in that category
 ... back to
 ... and should derive the
 ... we have laid out.
 ... the persons receiving
 ... at present. We recognize here
 ... do not have such
 ... as should be encourag-
 ... We
 ... have mentioned
 ... and mothers
 ... that
 ... putting well
 ... the country



Wodehouse 10107

With the larger group above that whom we feel constitute about 16% of the population or about 3,000,000 persons, we have recommended that those in the lower half of the group should receive two-thirds of their indigent program and for those in the upper half of that group that they receive one-third assistance. These are approximate figures, we do not know whether it should be 30% or 40% or what have you. We feel that these persons who are of restricted means should get this assistance on application. The application would come in two ways, if there is sufficient publicity given to the plan, if this plan is adopted on a Provincial or National basis I think it would be a Provincial basis in view of our Constitution, that they could apply in response to the publicity. The other way persons will get theirs is through doctors, because we have people in our offices almost every day and we are quite content to treat them at nominal fees or no fees. Some of these people express the wish that they would want to pay us and we are not against that, but we say "How can you do it, what is your financial situation? Perhaps you could qualify for this partial assistance, go to the Welfare Office or the appropriate office, state your case and see what they will do to help you."

DR. McMILLAN: In stating this matter I think it is important for us to get straight the question which you asked and you limited it to over 65 whereas Dr. Wodehouse's answer was concerned with those people with low incomes irrespective of age. There are two different thoughts on this matter; obviously from the



McMillan 10108

point of view of plans they would look at the 65 and over as a special group because of the increased costs of covering this particular area from the point of view of doctors. I think across Canada I would have to state the opinion is that they would prefer to see help provided to people because of income without specific reference to age.

COMMISSIONER FIRESTONE: I think that is a very desirable objective, you have the necessary mechanics and so we do not bring in the age of 65 and over but everybody who cannot pay for medical care services, is that correct?

DR. WODEHOUSE: Yes.

COMMISSIONER FIRESTONE: If I just for the moment wind up the discussion for 65 and over and come to the broader question which you have mentioned. Dr. Wodehouse, if we face here a factor of our population, 90% of which cannot afford to pay the premium coverage for 65 and over and as I say "if", because it depends on the results of our research work, our research staff, if we find that this is a case, would you perhaps feel that there is a case for a comprehensive coverage of all people 65 years and over on a voluntary basis?

DR. WODEHOUSE: On a voluntary basis?

COMMISSIONER FIRESTONE: On a voluntary basis?

DR. WODEHOUSE: Mr. Chairman, we have canvassed our Associations on this matter and it is their submission that they prefer to handle it the way we have outlined. As Dr. McMillan has said, we feel age is not



Wodehouse 10109

the criteria for assistance, that financial need is the criteria.

COMMISSIONER FIRESTONE: You may find or the Governments may find as they get involved in subsidizing or paying for this section of the population that this is the most expensive part of the subsidy arrangement and in fact will be most of the cost borne by the State to cover the people in this group. Now, if the State is going to pay a very large proportion of the funds required to carry out this program would it not make sense to have a program to cover people in this age group, making it available to everybody and having certain minimum standards across the country?

DR. WODEHOUSE: I think we cannot quite go along with that, because we will be tied in with the concept of 100% coverage of other groups. I would have to stop you there and say we do not feel it is an appropriate method of doing it. We feel our suggestion is the appropriate method, help those people on the basis of their financial need.

COMMISSIONER FIRESTONE: You are entitled to your views and we respect your views and are happy to have them.

DR. WODEHOUSE: This demonstrates one of the dangers of planning. For the administrative tidiness you sacrifice the principle and our principle is those who need help should be helped, but in order they have it administratively tidy it has been suggested they be included in one group. We take exception to this, we do not think for the sake of administrative tidiness one



Wodehouse 10110

should sacrifice principles.

COMMISSIONER FIRESTONE: Now, can we go to the broader question raised by you, Dr. Wodehouse, as to the method of paying for all those that you feel the State should pay either the total medical care costs and related costs or a portion of them. Did I understand you to say you had in mind a scheme whereby such costs would be paid by Provincial Governments? Is this the sort of thing you had in mind, or by the Federal Government, or both? What do you have in mind?

DR. WODEHOUSE: You are tying us down a little bit, but we are prepared to walk into this little piece of economy. We will start with tax money, municipal taxes and Provincial taxes and Federal tax money and our experience is there has to be at least some municipal participation in the determination of need, otherwise we end up with extravagant ideas of that need. Obviously the municipalities cannot cover the whole thing, they must have some assistance. The next step is the Provincial Government with some of our Provincial Governments associations have said they are unable to do it, to get Provincial funding so they have to go a step higher. We feel it is impossible at the beginning to define between one Government and another, it would have to be set up by the Government concerned as to the total of money being provided from some source to cover these various needs.

COMMISSIONER FIRESTONE: As I recall it and trying to bring the discussion to some concrete and specific ends, the Ontario Medical Association mentioned



Wodehouse 10111

to us they had approached the Ontario Government to extend the category of the indigent, the medically indigent and in line with the recommendation which you have made in your main submission that the financial resources of the Provincial Government is such that it is difficult to do without some assistance from the Federal Government, would you, therefore, assuming there are other Provinces in this similar situation --- we have been told there are, would you, therefore, be in favour of a plan whereby such assistance would be provided initially by Provincial Governments and administered by Provincial Governments but with financial assistance from the Federal Government?

DR. WODEHOUSE: Of course, now we are in the field of Dominion-Provincial relationships. We learn in other Provinces something about this matter and it is the same thing in our divisional Association, there is perhaps difficulty in working it out. We recognize there are at least four Provinces who require Federal funds in order to cover their general health service. We recognize that Federal funds have to be injected in some method, but this method is beyond us.

COMMISSIONER FIRESTONE: I am rather concerned with that area and I understand you endorse the principles and leave the mechanics to Dominion-Provincial patterns to be worked out.

DR. WODEHOUSE: That is it.

DR. McMILLAN: I think it is fair to say we have no controversy with existing welfare in the communities and we would include medical care under that,



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

McMillan 10112

and we would not criticize any handling methods and would
be prepared to accept them.



Wodehouse

10113

DR. WODEHOUSE: I wondered if I might
quote. It is on page 88 paragraph 212:

"It is not within the competence of
"The Canadian Medical Association to
"speak with assurance about the complex
"and delicate financial relationships
"between the Government of Canada and
"those of the provinces, much less to
"relate these to their respective
"traditional spheres of influence in
"health and education. However, it
"cannot fail to be apparent to one who
"has followed the hearings of this
"Royal Commission that in many provinces
"the limits of taxation appear to have
"been reached and that in some
"provinces difficulty is being experienced
"in the financing of existing health
"services."

I think that speaks for itself, sir.

COMMISSIONER FIRESTONE: Dr. McMillan,
if I may come back for a moment to the reference that
you made earlier, do I understand you correctly in saying
that you endorse the principles presently in existence
and in operation in health care programs?

DR. McMILLAN: In determining the
eligibility for welfare.

COMMISSIONER FIRESTONE: By welfare
you would include health coverage?

DR. McMILLAN: That is right. In some



Wodehouse

10114

1
2
3
4 provinces, by way of example, they pay the hospital
5 insurance premium. That is an example of what I mean.

6 COMMISSIONER FIRESTONE: Do I take
7 it from this, or perhaps it would be expanding your
8 views beyond what you intended, and if this is the case
9 please correct me, but you are endorsing the principles
10 that are presently in operation under the hospital
11 insurance program?

12 DR. McMILLAN: For determining
13 eligibility of welfare payments, yes.

14 COMMISSIONER FIRESTONE: Could we
15 perhaps broaden the question, Dr. Wodehouse, and again
16 this is applicable to any member of your panel, do
17 you endorse the principle of the hospital insurance plan
18 as it now exists, in general terms, or are there certain
19 specific areas that you have reservations about?

20 DR. WODEHOUSE: We have to go back,
21 you have asked a general question and I cannot give a
22 general answer, yes or no, on that matter. We have
23 been on record as endorsing the principle of hospital
24 insurance for many years, officially since 1949, but
25 unofficially for some period before that. Blue Cross
26 met with our encouragement and our approval for years
27 before Bill 320 was passed. Blue Cross, as I understand
28 it, covered 70% of persons on a voluntary basis. I
29 understand that even now many of the municipalities
30 picked up the tab or paid the per diem rate for the
person able to afford the Blue Cross premiums. Bill 320
was brought out with very little consultation, from our
point of view, very little co-operation. There are some



Wodehouse

10115

aspects of it that we don't like. In general we approve the increased availability of insurance. If you say do I approve of the principles of Bill 320, no, not necessarily. I approve of the increased facilities and availability of hospital insurance.

DR. RABSON: I think we should point out the aspects we don't like.

COMMISSIONER FIRESTONE: That would be very helpful.

DR. RABSON: This control through financial strangulation -- I don't want to use that word, but financial control through financial budgeting of which the Provincial Government have complete control. It is to this very specific point that we object to an overall government plan.

COMMISSIONER FIRESTONE: Well, you are quite right, Dr. Rabson. That is the most helpful. It anticipates really the next question I have in mind to put before you gentlemen. One of the principles of the hospital insurance program is that the Federal Government sets certain standards and requirements. It offers financial participation in provincial programs provided that the provincial programs meet the requirements and specifications of legislation. Now, sir, in making this program available to the provinces, some provinces have developed a program that covers every one in the province on a compulsory basis. Some provinces, like Ontario, have developed a program that covers some people on a compulsory basis, those that are in the wage earning categories on a payroll deduction



Wodehouse

10116

1
2
3
4 plan with employees of certain sizes and over, and then
5 other persons are covered on a voluntary basis. What
6 are your views on that principle which is already in
operation in the hospital field?

7 DR. WODEHOUSE: I feel that the
8 principle of voluntary participation by those who are
9 able to afford it should be encouraged. We feel that
10 government intervention on behalf of those in financial
11 need should be instituted.

12 DR. RABSON: To give you one example
13 of Federal Government interference, Bill 320 says the
14 hospital plan must be on equal terms and conditions to
15 all participants. This means that if some provincial
16 governments desire to have different premiums for
17 different income levels, they are unable to do it.
18 I believe that would be an equitable way of putting
19 in the hospital plan. This again is the element of
control to which we object.

20 DR. WODEHOUSE: If I could come back,
21 Dr. Firestone, to one specific thing, four of the
22 provincial hospital budgets are frozen for this year
23 including the Chairman's own province of Saskatchewan.
24 They are frozen. There is no leeway for any expansion
25 whatsoever. I believe it is true again the facilities
26 for retiring previous debts accumulated prior to the
27 institution of Bill 320 and its application in 1959 are
28 lacking. There is no mechanism for the hospital to
29 get money to pay the interest charges due on the monies
30 which they have already owed. There is no provision
in the Hospital Insurance and Diagnostic Services Act



Wodehouse

10117

1
2
3
4 for the coverage of persons suffering mental ill health.
5 This is separate from the Hospital Insurance and
6 Diagnostic Services Act regulations. This is based, I
7 presume, on the fact that when the Act got in in 1959
8 this was a provincial responsibility and it was left
9 as such. We feel it is wrong, that mentally ill people
10 should be treated on the same basis as other people.
11 The same thing applies to tuberculosis sanitoriums.
12 That is not as much of a problem, as you know and have
13 heard, because tuberculosis is becoming less of a
14 problem. The general procedure is wrong in that they
15 are excluded from the benefit. There is no provision
16 in many provinces for the special recognition of teaching
17 hospitals. Teaching hospitals require more money by
18 the nature of their duties in teaching and research and
19 all this type of thing. These are not recognized under
20 Bill 320. These are three examples that I bring forward
21 of our objections to overall legislation. Perhaps an
22 amendment to the legislation could improve them.

23 COMMISSIONER BALTZAN: What is the
24 position of the chronically ill?

25 DR. WODEHOUSE: If there is a
26 chronically ill hospital, but there are not enough
27 anyway in this country, they are included on a lower
28 per diem rate, but they are included. There are not
29 enough of them. There are not enough convalescent
30 hospitals, not enough rehabilitation centres.

31 DR. RABSON: One other thing, Mr.
32 Chairman, to show to you the hiatus in planning that
33 could occur under Bill 320, no consideration was given



Wodehouse

10118

1
2
3
4 for teaching hospitals. This is covered in our brief.
5 We know it is found that the cost is more because it
6 is much longer because they are complicated cases
7 requiring more investigation. In all these things we
8 think it is very difficult to get this changed when
9 they are under government control. Under a voluntary
situation changes would be facile.

10 DR. WODEHOUSE: I would point out
11 again with Bill 320 the Hospital Insurance and Diagnostic
12 Services Act, it is becoming increasingly difficult to
13 get voluntary donations for the building of hospitals
14 and increasingly difficult in this community to get
15 municipal participation. Our retiring chairman of the
16 Metropolitan area, one of his last actions was to
17 refuse a committee to investigate the bed needs in this
18 city, much less participate financially. He said this
19 is government's responsibility. I guess he meant another
20 level of government. This is one of the outcomes of
21 Bill 320, fewer voluntary dollars and fewer municipal
22 dollars.

23 THE CHAIRMAN: We will take a short
24 recess.

25 ---Short recess.

26 COMMISSIONER FIRESTONE: Before
27 proceeding with the questioning I would like to put on
28 the record a point of Dr. Trueman brought to my
29 attention. The figures I quoted with respect to the
30 \$223.00 and the \$315.00 representing an estimate of

for certain hospitals. This is covered in our 1947. We know it is true that the cost is more because it is much longer because they are complicated cases requiring more investigation. In all these things we think it is very difficult to get this covered when they are under government control. Under a voluntary

J. JOHANNES: I would point out

again with Bill 820 the Hospital Insurance and Diagnostic Services Act, it is becoming increasingly difficult to get voluntary donations for the building of hospitals and hospitals. Difficult in this country to get municipal participation. Our retiring chairman of the Ontario Health Board, one of his last actions was to refuse a committee to investigate the bed needs in this city, much less participate financially. He said this is government's responsibility. I guess he meant another level of government. This is one of the outcomes of Bill 820, fewer voluntary hospitals and even municipal dollars.

THE CHAIRMAN: He will take a short

one ending with the question I would like to put on the record a letter of Dr. Freeman in regard to my statement. The figures I quoted with respect to the hospital and the other representing an estimate of



Wodehouse

10119

1
2
3
4 premiums required to pay for average medical expenses,
5 and I am quoting now from the book of Dr. Somers are
6 exclusive of hospitalization for mental illness or
7 tuberculosis. That is the end of the quote. The
8 implication is it does cover expenses of general
9 hospitalization. Thank you for bringing this matter
to my attention.

10 Dr. Wodehouse, just before the break
11 we were dealing with the principles of the hospital
12 insurance plan, and the particular area I would like
13 to have you discuss, if possible, sir, is the manner
14 in which this plan operates in Canada whereby in some
15 provinces this plan has been applied to everybody in
16 the provinces, when some provinces like Ontario, the
17 plan compels a certain number of people to belong to the
18 plan leaving it to the rest on a voluntary basis. As
19 I understand from the Ontario Hospital Insurance
20 Commission about 65% are covered on the payroll,
21 compulsory coverage and about 30% on a voluntary basis,
22 making a total of 95%, about 5% are not covered at all.
23 They are voluntary between the 65 and 100%. Now, what
24 are your views about this particular method of
implementing the hospital insurance plan in Canada and
in the Province of Ontario?

25 DR. WODEHOUSE: You are taking the
26 compulsory enrolment of the total population of the
27 province as against the mixed bag of semi-compulsory.

28 COMMISSIONER FIRESTONE: Or you may
29 feel neither of the two systems meet with your approval.
30 Please say so.



Wodehouse

10120

1
2
3
4 DR. WODEHOUSE: Mr. Chairman, we
5 favour the voluntary procedure. We are opposed to
6 compulsion.

7 COMMISSIONER FIRESTONE: Do I under-
8 stand from that you are not in favour of this system
9 as it now operates in the Province of Ontario whereby
10 two-thirds of the population are being covered on a
11 compulsory basis:

12 DR. WODEHOUSE: I am sorry I missed
13 that question.

14 COMMISSIONER FIRESTONE: Do I understand
15 from your answer, sir, that you are not favouring the
16 present Ontario hospital insurance program which entails
17 two-thirds of the population directly being covered on
18 a compulsory basis and the rest on a voluntary basis?

19 DR. WODEHOUSE: Mr. Chairman, I
20 think I have said previously that we favour the hospital
21 insurance program in that it has extended the hospital
22 coverage, hospital insurance coverage to a great number
23 of people. We are not necessarily in favour of the
24 implementation or the sets of rules or regulations that
25 are contained therein, but the extension of insurance
26 to a large proportion of the people is a good thing in
27 this very expensive area. If I may quote you on page
28 34 of our brief, paragraph 93:

29 "It should not be inferred from these
30 "comments on the imperfections of hospital
"insurance in Canada that the medical
"profession is not favourably disposed
"to the purposes of the plans. From

DR. WOODHOUSE: Mr. Chairman, we

favor the voluntary procedure. We are opposed to

COMPELLED BY PARAGRAPH 23: To understand

stand now that you are not in favor of this system
as it now operates in the Province of Ontario whereby
two-thirds of the population are being covered on a

compulsory basis

DR. WOODHOUSE: I am sorry I missed

that question.

COMPELLED BY PARAGRAPH 23: To understand

two years ago, sir, that you are not favoring the
present Ontario hospital insurance program which entails
two-thirds of the population directly being covered on
a compulsory basis and the rest on a voluntary basis?

DR. WOODHOUSE: Mr. Chairman, I

think I have said previously that we favor the hospital
insurance program in that it has extended the hospital
coverage, hospital insurance coverage to a great number
of people. We are not necessarily in favor of the

implementation to the rest of the population that
we outlined therein, but the extension of insurance
to a large proportion of the people is a good thing in
this very expensive area. If I may quote you on page

20 of our bill, paragraph 23:

"It shall not be a ground for the

"complaints on the implementation of hospital

"insurance in Canada that the medical

"protection is not favorably disposed

"to the purposes of the plan. For



Wodehouse

10121

"the inception, doctors have co-operated
"actively to make hospital insurance an
"effective means of providing for a
"contingency which lends itself
"particularly well to insurance coverage.
"Medical staffs of hospitals have
"carried out responsible roles in
"administration. They serve on all of
"the staff committees which are required
"by hospital accreditation and, in
"addition, on admission and discharge
"committees, pharmacy committees and the
"other bodies which relate to the
"optimum functioning of the insurance
"system. Hospital insurance has
"operated in the promotion of good
"medical care; it provides a measure
"of financial stability for the
"hospitals, and for that most important
"individual, the patient, it has provided
"a sense of security not previously
"enjoyed."

Mr. Chairman, I take you back to
three statements in that paragraph: One is that it
lends itself particularly well to insurance coverage.
There are never so many beds in any province --- we
hope they are going to increase rapidly in urban areas, but
at the same time there are never so many beds that it
is completely a predictable cost.



Wodehouse

10122

You know they are all going to be full all the time, but you know exactly what it is going to cost within the realm of the increasing deficit which every province has experienced during the last few years. This is different to medical services. If you go to the doctor you see him. If you try to go to hospital in this town you don't necessarily get in for two or three weeks. So there is a reserve applicable to hospitals, not applicable to medical services.

The financial stability of hospitals in this area - as I pointed out, there is some financial instability, there are limitations on the carrying of capital debt, etc. I quite agree many of our hospitals were in very critical financial state before this thing was brought in. I think that problem might have been settled in some other way quite honestly.

We were in favour of people having coverage, but not necessarily thrust down their throat.

COMMISSIONER FIRESTONE: As I understand it, Dr. Wodehouse, you are in favour of the principle of hospital insurance. You would prefer to have that principle applied on a voluntary basis?

DR. WODEHOUSE: That is correct, sir.

COMMISSIONER FIRESTONE: Now, in fact, it has, in the Province of Ontario, been applied on a combination of compulsory and voluntary?

DR. WODEHOUSE: Yes.

COMMISSIONER FIRESTONE: Do you approve of the compulsory feature as it now exists in Ontario?

DR. WODEHOUSE: I don't approve of it



Wodehouse

10123

under provincial or governmental legislation. When you get around to conditions of group enrolment applicable in some of our insurance plans, from necessity we have had to go along with a certain percentage, but it does not have to be the total group and, I think, sir, as I said before, Blue Cross offered coverage to 70% of Canadians prior to Bill 320 being introduced and I think the other 30% are made up of indigents, and semi-indigents and it would have been much cheaper, and I think adequate, had Blue Cross been encouraged and had government interested itself in these areas of need.

DR. RABSON: Universal hospital insurance provided by government has, in no way, eliminated a means test in those provinces where there is a premium and most people who are thoughtful about health insurance believe the patient should make a contribution by way of a premium. There is still a means test to find out the people who cannot pay a premium, so I think that this myth that hospital insurance is made available without a means test should be destroyed.

DR. WODEHOUSE: Talking about hospital insurance, this is not meant to be critical in any way of a province in which I don't live, but in the Province of New Brunswick, conditions have been changed. They had a deficit of 29 million, of which 7 million was attributable to their hospital scheme. In other provinces we have no way of knowing what the hospital schemes cost.

Parts are published and parts - I won't say they are hidden intentionally, but it is difficult to



Wodehouse 10124

find out what they cost. I know that in Ontario we are faced with steadily increasing deficits, in astronomical sums, in the next few years.

Things have been destroyed by Bill 320. I am concerned with the health of the students in this university and I am sure that the only hospital accommodation in standard wards would cost them \$25 a day, and we have made every endeavour to encourage the participation of all the students in hospital insurance. I am pleased to say that 90% of them, in a survey of 6,000, have hospital insurance of some kind or another, voluntary or compulsory, but I think it is impossible for me to tell a student arriving, for example, from Saskatchewan or from B.C., whether his coverage will be eligible in Ontario. This was possible under Blue Cross. All you did was pick up your tabs and have them paid in the province you moved to.

COMMISSIONER BALTZAN: In the same context, I have been wondering about one or two or three points that you called our attention to in the issue of the Canadian Medical Association, where this sort of compulsory hospital service was available over a period of years. Number one, you say that the period of in-hospital care for the indigents for which the province had previously accepted responsibility was reduced from 21 to 14 days. What was the necessity there in your studies?

THE CHAIRMAN: Well, I wonder, Dr. Wodehouse, if we had better not stay on the subject we are talking about at the moment?



...and with steadily increasing incidence, in anatomical
terms, in the next few years.

There have been deaths reported by 1911-1912.

I am concerned with the fact that the only hospital in the
university area, and the only one with a surgical department,
is situated in a remote part of the city, and
we have made every endeavor to have the patients

tion of all the patients in hospital is very small. I am
pleased to say that 80% of them, in a survey of 6,000,
have hospital insurance of some kind or another, which
may or may not be sufficient, but I think it is a very good

to tell a student arriving, for example, from the Midwest
that he will find his hospital insurance will be sufficient in
most cases. This is a possible source of error. All you
have to do is go to the hospital and have them paid in the

provision you need for.

THE CHAIRMAN: Well, in the
context, I have been wondering about one or two or three
points that you called our attention to in the issue of

the American Medical Association, where this sort of
continuity of hospital service was available over a period
of years. I am sure, you say that the kind of in-
crease in care for the indigent for which the provision
has previously been responsible is now being met from
the fact that what was the responsibility there is now

THE CHAIRMAN: Well, I wonder, if
we could, if we had a few more of the sort of
the fact that the



Wodehouse

10125

DR. WODEHOUSE: I am quite prepared to do what you direct.

COMMISSIONER BALTZAN: I will defer that.

THE CHAIRMAN: It may make progress a little slower maybe, but carry on.

COMMISSIONER FIRESTONE: On this question of compulsion, and this is really the only question I am putting to you, you have dealt with many of the inadequacies of the program and you have also mentioned a number of adequacies, but just on this question of compulsion: we have in operation in some provinces a system that is compulsory for all. We have in some provinces a system that, like Ontario, that combines compulsion and voluntary. Do you approve of the principle of compulsion which is presently in existence in Ontario, in the Ontario Hospital Insurance Scheme, with respect to one part of the population?

DR. WODEHOUSE: I have said, sir, already my views on that. I approve only to the degree that it has encouraged some enrolment, but I do not approve of the compulsory aspect for the population as a whole.

I cannot change horses and say it was wrong for P.S.I. or Ontario Hospital Commission to insist on some group enrolment.

COMMISSIONER FIRESTONE: All of my question refers to the 65% approximately of the Ontario population which is presently covered by a compulsory system of prepayment. Are you in favour of this or are you not?



Wodehouse

10126

DR. WODEHOUSE: I am in favour of 65% of the population having insurance coverage. I have already pointed out that 70% had it under Blue Cross.

COMMISSIONER FIRESTONE: I appreciate that, but we are talking about the method being a compulsory system, and the answer is still yes?

DR. WODEHOUSE: The answer to what?

COMMISSIONER FIRESTONE: To my question as to whether you favour a system whereby 65% approximately of the population ---

DR. WODEHOUSE: No, I don't. As a matter of fact I feel that the original methods of enrolment were perfectly adequate, and we didn't have to have that degree of compulsion. We had 70% before this plan came in.

COMMISSIONER FIRESTONE: Therefore, the answer to my question is no?

DR. WODEHOUSE: That is right, sir.

COMMISSIONER FIRESTONE: If the Federal Government were to think in terms of developing a plan whereby it would make a financial contribution available to provincially-operated medical care plans covering, say, certain sectors of the population, and at this point cover only those sectors which you have recommended; now, some provinces may say that if these funds are made available to us we wish to have a comprehensive and compulsory plan. Some provinces may say, no, we don't want a compulsory plan, we want a voluntary plan that provides for coverage of what we call the indigent medically. Can you visualize a program whereby the



Wodehouse

10127

Federal Government could make such funds available to provinces who wish compulsory, comprehensive and provinces who wish voluntary, partial?

DR. WODEHOUSE: Once again, we are in the province of semantics. I don't know how you can say to a person in the medically indigent group that this is compulsory when you provide medical care. It is his business whether he uses it or not. If he wants to go to his old friend John Smith around the corner who has looked after his family for 40 years, and will continue to do so for nothing, that is his privilege. He does not have to use his medical care card. There is no compulsion in the marginal income group. If they want it, they can go and ask for it. There is no compulsion, and in our minds there should not be any compulsion.

COMMISSIONER FIRESTONE: These are the views you put forward; we must agree. But we are talking now of a federal plan whereby the Federal Government might be making funds available to the provinces to develop a medical care plan and in the wisdom of the people of some provinces, and the Provincial Government, they may wish to have a plan that covers everybody on a compulsory basis. Would you say that such federal funds should not be made available to that particular province?

DR. WODEHOUSE: It is our Association's opinion that compulsion is not necessary, it is undesirable, and should not be implemented, and our Association would oppose even the leeway given to provinces to institute a compulsory plan from federal funds.



Rabson

10128.

DR. RABSON: I believe that in order to support that we have no evidence that compulsion in State schemes in any way raises the health standards of the people, nor do we have any evidence to say ---

THE CHAIRMAN: I think we are going to stay with the questions, and not go into all the by-paths. We cannot chase every rabbit down every lane.

COMMISSIONER FIRESTONE: Having said that the way in which to approach this thing is through a voluntary approach ---

DR. WODEHOUSE: Are we now talking still about our two low-income groups, or are we expanding this?

THE CHAIRMAN: Oh no, you have left the low-income group on the last question. The last question had no relationship to the low-income group.

COMMISSIONER FIRESTONE: That is correct, sir. Thank you.

-

-



hm

Wodehouse

10129

1
2
3
4 COMMISSIONER FIRESTONE: As I understood
5 you to say in the report that you visualize you have
6 already about 56% of the Canadian population covered
7 in various insurance plans and you hope to raise this
8 to about 67% in 1970. Would you feel the expansion of
9 these plans plus the expansion which you have recommended
10 of coverage for the indigent, the medically indigent,
11 would give us fairly substantial coverage of the
12 Canadian people? Did I understand you correct on this
13 point?

14 DR. WODEHOUSE: I think your use of
15 the term "substantial coverage" is excellent. I have
16 heard many politicians speak of 60% and they thought
17 they were doing well.

18 COMMISSIONER FIRESTONE: You see, you
19 talk to politicians and we talk to doctors. If I might
20 continue: This 67% is people that are covered with
21 some form of insurance but are we not concerned when we
22 talk of prepayment medical care services, the health
23 services with the total cost of such services rather
24 than who is insured and who is not because people that
25 have inadequate insurance may be just as badly hurt
26 as some people who have no insurance. It depends on
27 their income status, size of family and many other
28 factors. Therefore, I wonder if the question does not
29 also arise within any development of a plan looking
30 forward to a more comprehensive coverage in prepayment
we should think in terms of what proportion of the cost
of medical care services and for health services are
covered. Has your economist made any estimate of what



Wodehouse

10130

1
2
3
4 proportion of health costs are presently covered in
5 Canada through the medium of prepayment?

6 DR. WODEHOUSE: Through the medium of
7 prepayment, I know of no such thing.

8 COMMISSIONER FIRESTONE: If I might
9 just define prepayment; it covers voluntary plans ---

10 MR. FREAMO: If you are speaking of
11 the very broad subject of health to take into considera-
12 tion drugs, et cetera, I do not think we have made a
13 distinctive study of the proportion of total cost. This
14 is total cost on monies personally paid involved in
15 prepayment. We have been very interested in studying
16 the matter of existing programs over a period of ten
17 years in terms of medical services only. That is the
18 increasing proportion of costs which are covered under
19 insurance contracts. Now, the coverage, therefore, is
20 getting more comprehensive than ten years ago but we
21 do not have an answer to that specific question.

22 COMMISSIONER FIRESTONE: Would it
23 perhaps be a little more helpful if I were to limit
24 my questions to medical care services only and relating
25 to costs on prepayment to the total medical bill of the
26 nation. Is such a submission available?

27 MR. FREAMO: No, we assume in terms
28 of medical care the total medical care in the country
29 is of the order of \$350 million to \$400 million, some-
30 thing in that particular area. This is very much in
the nature of an estimate. We have now, getting back
to insurance, we have what we believe are reasonably
comprehensive contracts available but, again, we are not



Freamo

10131

1
2
3 aware of even what proportion they cost or they cover
4 because there are areas of extra billing involved in
5 almost every contract provided. Our total medical bill,
6 we consider to be in the area of \$350 million.

7 DR. WODEHOUSE: When you talk of
8 \$350 million and \$400 million, this is a figure which is
9 so very frequently misapplied by people who wish to do
10 so. That includes all the cost of operation of the
11 physicians and doctors concerned and on the average it
12 means about 40% of what a doctor earns goes out in
13 upkeep so 40% of that is not going into the doctors'
pockets, it is going into the running of the facilities.

14 THE CHAIRMAN: That is not the question,
15 the question is what is going out of somebody else's
16 pocket. I do not know that you necessarily need to be
17 so touchy as to justify your position every time.

18 DR. WODEHOUSE: I accept your ruling.

19 COMMISSIONER FIRESTONE: On this
20 question of \$350 million to \$400 million being an
21 approximate estimate, I might say we have asked our
22 research staff to develop such estimates and are looking
23 forward to receiving them. However, for a basis for
24 discussion would you know approximately how much the
25 medically-sponsored plans in Canada and the commercial
26 insurance companies pay out a year for medical care
27 services?

28 MR. FREAMO: Well, Mr. Chairman, the
29 only figures available are now two years old and we are
30 trying to talk about something currently. Again, my
estimate would be in the current year between \$175 million



Freamo

10132

and \$200 million.

COMMISSIONER FIRESTONE: You are suggesting that currently about half of the total medical care costs are covered in Canada through prepayment schemes?

MR. FREAMO: We were talking about specifically T.C.M.P. plans and the commercial carriers. There are, of course, medical welfare plans operating in six of the provinces which would add very slightly.

COMMISSIONER FIRESTONE: Well, if you recall, I gave you a definition of coverage and I specifically referred to the so-called 57% and 67% coverage in medical insurance plans so according to these estimates you feel about one-half of the total medical care bill is presently covered by insurance by the carriers as defined.

Well, I have been trying to get this information and in the absence of Canadian estimates which we will be receiving in due course, I looked again at Dr. Somers' book which she prepared for the United States and I might read this relevant part to show you what the situation appears to be in another country without in any way suggesting this necessarily applies to Canada. I quote from page 500 of that book:

"In 1958 health insurance was meeting,
"on average, one one-fourth of the
"medical bills of the insured families
"and only one-fifth of the nation's
"private expenditures for medical care."
That was 25% and the other was 20%.



and the other

the other

and the other

the other

the other

the other

the other

the other

the other

the other

the other

the other

the other

the other

the other

the other

the other

the other

the other

the other

the other

the other

the other

the other

the other

the other



Wodehouse

10133

1
2
3
4 DR. WODEHOUSE: May I ask at this
5 point these words "medical care insurance", are they
6 talking about doctors' services or are they talking
7 about drugs and everything else?

8 COMMISSIONER FIRESTONE: If I may
9 finish. I quote:

10 "Hospitalization benefits, proportionately
11 "the most adequate, met only 58%
12 "of the nation's private hospital bill.
13 " The proportion of non-surgical
14 "doctors' bills covered was only 7%;
15 "protection against drug, dental and
16 "other expenses were almost non-
17 "existent."

18 Now, mind you, this is the situation
19 in the United States in 1958 and I am not claiming the
20 figures apply to Canada. I am not making a claim these
21 figures have not changed, either. All they suggest to
22 me is a possibility that our research staff might come
23 up with answers which suggest that perhaps only one-
24 quarter of our medical care costs, physicians' services,
25 covered by the plans that I have mentioned. I say it
26 may or it may not.

27 DR. WODEHOUSE: On a prior privilege
28 I think it would be better until Commissioner Firestone
29 waits until the staff comes up with the figures rather
30 than reading from a book covering other places.

COMMISSIONER FIRESTONE: If I may
come back to the statement I made at the very beginning,
I am trying to get the best views I can from your



Wodehouse

10134

1
2
3
4 Association. I can assure you I would prefer to have
5 all the research results and have them available to me
6 and to you and we could have discussed them but we
7 cannot have them. I am endeavouring to get your advice
8 and, therefore, I am going beyond this certain basic
9 assumptions might be altered in the light of research
10 results.

11 DR. WODEHOUSE: May I interject again?
12 May I refer you back to page 1 of our brief where we
13 say:

14 "We are fully conscious of the importance
15 "of the research which is proceeding
16 "and we are aware that many of the
17 "studies will not be completed until
18 "after the public hearings of the
19 "Commission have ceased. These
20 "considerations have led us to offer
21 "the services of this Association or
22 "selected members to aid the Commission
23 "in the interpretation of the data
24 "which are produced."

25 This offer still stands, you may have
26 our criticism our helpful suggestions at any time you
27 wish them.

28 COMMISSIONER FIRESTONE: We are very
29 grateful to you, sir. I am proceeding on the premise
30 that we will have this information and I would like to
know, without producing a resolution of anything that
might develop on the question of whether we have 25%
coverage or 50% coverage, how do we expand that from 25%



Wodehouse

10135

1
2
3
4 to 50% to 100% on medical care costs. I am not talking
5 as to the percentage of people covered, I am talking of
6 the coverage of the total medical care costs.

7 THE CHAIRMAN: If you gentlemen in
8 front of us, as you are well entitled to say that you
9 have not any information upon which to give an opinion
10 then I think we will have to accept that. I take it
11 that is what they have been saying for some time.

12 DR. McMILLAN: There is one answer
13 we can give you very definitely and that is the total
14 cost of the needy and near needy would be included in
15 our projected figures. We believe that they should
16 have all their medical services.

17 THE CHAIRMAN: This is just another
18 propaganda speech. Now, I am going to try and ---

19 DR. McMILLAN: He asked for a
20 percentage and I said 100%.

21 MR. FREAMO: I would like to make a
22 comment about the quotation because we did have the
23 opportunity of having Mrs. Somers in Canada and she had
24 a look at some of our Canadian insurance arrangements.
25 She concluded from her look that they were very much
26 different from what she was used to in the United States.
27 I think the statistics amassed in this particular
28 section of the book, she would be the first to agree, would
29 have no particular application in this country if they
30 do not know, as we know, the comprehensive type of
service plan in the States to nearly the same degree.
I think we are not talking about exactly the same things
in this instance.



Wodehouse

10136

1
2
3
4 COMMISSIONER FIRESTONE: I am very
5 much obliged to you for this qualification and that is
6 why we are looking forward to receiving the results
7 of the research work. However, the problem we are
8 facing still exists, whatever the proportion will turn
9 out to be as the result of this research, how do we
10 achieve complete or near complete coverage under the
11 scheme that you have proposed of all medical costs of
12 the Canadian people in terms of cost rather than in
13 terms of proportion of the persons covered?

14 DR. WODEHOUSE: I think I have given
15 that a couple of times but I will go through it again
16 if you like. I feel our present voluntary mechanism
17 should be expanded to its full capacity and that
18 encouragement should be given to the citizens of the
19 country to avail themselves of these facilities as they
20 become available as they will very rapidly in the next
21 few years. For the two groups which we have spoken
22 of in our brief government support should be given.

23 COMMISSIONER FIRESTONE: Let us deal
24 for a moment ---

25 THE CHAIRMAN: Well, I think we have
26 exhausted the subject, in my humble judgment.

27 COMMISSIONER FIRESTONE: I was just
28 turning to follow up the subject we have arrived at
29 and come to the point you have just raised of the
30 medically indigent. On this medical indigent group,
who do you feel should be included in that category?

DR. WODEHOUSE: Well, we have outlined
that fairly specifically in our brief, as you know.

WOLFELORE

ON THE 12th OF FEBRUARY, I AM VERY

much obliged to you for this qualification and that is

why we are looking forward to receiving the results

of the research work. However, the problem we are

facing still exists, whatever the proportion will turn

out to be as the result of this research, how do we

achieve complete or near complete coverage under the

scheme that you have proposed of all medical costs of

the Canadian people in terms of cost rather than in

terms of proportion of the persons concerned.

DR. WOLFELORE: I think I have to say

that a couple of times but I will go through it again

if you like. I feel our present voluntary mechanism

should be expanded to its full capacity and that

encouragement should be given to the extension of the

country to small themselves of these facilities as they

become available as they will very rapidly in the next

few years. For the two groups which we have spoken

of in our brief government report should be given.

COMMISSIONER FLETCHER: Let us deal

for a moment --

THE CHAIRMAN: Well, I think we have

examined the subject, in my humble judgment.

THE CHAIRMAN: Well, I was just

returning to follow up the subject we have now --

and come to the point we have just raised of the

medically indigent. On this report, however, from

who do you feel should be included in that category?

DR. WOLFELORE: Well, we have outlined

that category specifically in our brief, as you know



Wodehouse

10137

1
2
3
4 COMMISSIONER FIRESTONE: In terms of
5 statistics.

6 THE CHAIRMAN: Perhaps Dr. McMillan
7 would like to say now what I thought was not relevant
8 a few minutes ago but is relevant now; you want 100%?

9 DR. McMILLAN: There are two figures
10 on the question of who could be covered. We were
11 prepared to study and accept the criteria now used
12 locally that may be provincial or municipal to determine
13 who are in receipt of welfare and within the provincial
14 government in an area we have said we would like to
15 have this group covered. We have not made any contro-
16 versy about it. As far as the extent of it goes, we
17 would continue talking about 100% of their medical
18 needs. That explains both the persons covered and the
19 degree of coverage.

20 COMMISSIONER FIRESTONE: If I may
21 just carry on with this question of the coverage in
22 terms of numbers. As I understand it you have suggested
23 two groups be included, one group which is called the
24 indigent and the other group is called the medically
25 indigent and indigent covers people who are presently
26 on welfare plans or in receipt of welfare assistance
27 of one type or another.

28 DR. WODEHOUSE: We think it should be
29 be interpreted generously.

30 COMMISSIONER FIRESTONE: You feel your
definition of indigent would go further than people
presently covered under a welfare plan. How would you
like to see that extended?



...of the ...

...of the ...

...of the ...

...of the ...

...of the ...

...of the ...

...of the ...

...of the ...

...of the ...

...of the ...

...of the ...

...of the ...



Wodehouse

10138

DR. WODEHOUSE: Go a little further.

This is based on figures we have from two of our provinces and also figures from our Ontario Hospital Services Commission. We have found persons who have not paid their premium, some of them are eligible for this welfare treatment and have not gotten it for various reasons. That is what we mean by being generous across the country. Of course, it varies from one province to another and it may be quoting figures as examples, five per cent in this province and it may be 28% in some other province but averaging this out across the population of Canada this amounts to 8% or 1,520,000 people.

As far as the other people are concerned we assume that they are dependent and so come up with the figure of three million people, about twice the size of the welfare who need help. About this other group, we have broken it down into the lower half who need two-thirds assistance and the upper half who need probably one-third assistance and we have delineated in our brief how this should be done, they make application to the local authority and on recommendation of that authority they are granted the assistance.



CONFIDENTIAL

CONFIDENTIAL: No a little bit

This is based on figures we have from two of our
 countries and also figures from a third country.
 services Commission. We have found persons who are
 not paid their premium, some of whom are idle. This
 this welfare treatment and have not gotten it for
 various reasons. That is what we mean by being treated
 across the country. In some, it comes from the
 province to another and to say we cannot distinguish
 examples, like for cost in this province and it can be
 18 to some other and in a not everywhere this and
 across the population of Canada this group is to be

As far as the other regions are concerned
 we assume that they are detached and so come up with
 the figure of three million people, about twice the
 size of the welfare population. About this other
 group, we have known it for a long time. The
 need two-thirds assistance and the other third who need
 probably one-third of assistance and we have not known for
 some time. This should be done, then we should know
 to the local authority and on recommendation of that
 authority they are granted the assistance.



Wodehouse

10139

COMMISSIONER FIRESTONE: I would like to understand that a little bit more, what criteria; after all, whether you perform it either by the municipality or other level of government, they must have certain criteria to selecting the medically indigent. Would you include in the medically indigent group the unemployed?

DR. WODEHOUSE: A lot of the unemployed are not medically indigent immediately. They become medically indigent if they are unemployed a sufficient length of time. A fair number who are unemployed persons, for example, have medical service insurance and they have their medical service insurance premiums continue to be paid for them by their employer. For a straight 100% taking in of the unemployed group as being persons who need assistance - no, this is wrong.

It reverts back to the same type of discussion we had about the over 65's. It isn't 100%.

COMMISSIONER FIRESTONE: In other words, you would like to see the unemployed undergo a means test before they are eligible for this assistance?

DR. WODEHOUSE: I would like to see those unemployed who have their premiums paid by their employers, continue to have those premiums paid and if circumstances remain sufficiently bad for them, sufficiently long, they are in trouble, I would like to have some means of their getting medical assistance, the same way that people will in other areas of living.

COMMISSIONER FIRESTONE: You would like to see them treated, once they have exhausted the



Wodehouse

10140

benefits from their employer, treat them like you suggest the indigent should be treated?

DR. WODEHOUSE: If they then attain indigency levels. I don't know if they all do this. There are seasonal employments in this country. They are not all paupers in the season they are not working although many of them draw unemployment insurance.

COMMISSIONER McCUTCHEON: You must be thinking of the British Columbia fishermen.

DR. WODEHOUSE: That might be one category. I can think of another province.

COMMISSIONER FIRESTONE: Dr. Wodehouse, some of the witnesses have pointed out to us that the people that may be suffering in this so-called medically indigent group are not people that are either unemployed or 65 years of age. They may be people earning a reasonable salary. Because of the size of the family or of other obligations are unable to pay for insurance premiums either in full or part.

DR. WODEHOUSE: I do not think there is any central government or authority that can lay down blanket rules which would work across the country. I don't think provincial authorities can lay down blanket rules and regulations which will work to achieve social justice in every area of the provinces concerned.

I think it has to be a combination of provincial assistance with local determination of who in the community needs it and our welfare officers, as we know, are well-trained in this. They take the atmosphere of economic conditions in the community in



Wodehouse

10141

which they live. They know Joe Blow and his six children, they can go in and look at his house and know how badly off he is. These are the persons who do it, not some central officers by means of regulations.

COMMISSIONER FIRESTONE: Yesterday afternoon we had representatives of the School of Hygiene, University of Toronto, present and in answer to a question by one of the Commissioners we were advised that there may be a good many families in the middle income group that may find it difficult to pay these premiums.

COMMISSIONER McCUTCHEON: We got the ridiculous answer that 80% of the people in Canada couldn't pay. That's the answer we got.

COMMISSIONER FIRESTONE: Without adding to the valued judgment of my fellow Commissioner, and just dealing with the answer we got, I am putting before you, if it is true and, again, our research studies will develop this; if it is true that there are a large number of people in the \$6,000 and less income group that may find it difficult to pay for all the comprehensive health care benefits; that is not only doctor bills, etc., but as it was suggested to us yesterday, would you then feel that these families should either not be fully covered or would you suggest that they go to the welfare officer and be subjected to the means test?

DR. WODEHOUSE: Mr. Chairman, I am afraid I have to make a little bit of a speech on this matter. The persons that presented that brief are my brothers at the university and one of the things of which



...they live. They know the law and the law is not
...in fact, it is not the law and the law is not
...There are the laws of the land, the laws
...of the land.

...we had representation of the people of the
...University of Toronto, present and in answer to a
...by one of the Commissioners who had advised
...there may be a good many families in the whole
...income group that may find it difficult to pay their
...president.

...of the Commission, I am sure, we are the
...ridiculous answer that 50% of the people in Ontario
...shouldn't pay. That's the answer we are

...to the valued judgment of my learned friend, Mr. J.
...just dealing with the question of law, I am going to follow
...yes, it is in fact and, again, our answer is that
...will be the case; it is in fact that there is a large
...number of people in the \$5,000 and less income group

...that may find it difficult to pay for all the necessities of
...health and housing; that is not only housing, electricity, etc.,
...but also it is suggested to be necessary, what is the
...that these families should not be able to
...and on the other hand suggest that they are not able to
...and it is suggested in the same way that

...I have to make a further point, it is a point of fact
...the persons who are referred to as being in the
...at the University and one of the main reasons



Wodehouse

10142

we are very proud is that there is freedom of speech on the part of our staff. Another thing of which we are very proud is that we are free to criticize our colleagues.

I haven't had an opportunity of reading it. I only heard a portion of it presented verbally but the part I heard presented verbally was the impractical idealistic dream of an ivory tower social planner. This figure of 80% of the population not being able to obtain coverage is not correct. We have 60% who are doing it right now.

COMMISSIONER McCUTCHEON: That is a valued judgment.

COMMISSIONER FIRESTONE: They are not necessarily fully covered, as far as prepayment of their policy is concerned. They have some form of coverage but the problem we are facing is: should we extend that prepayment coverage to everybody, with respect to 100% of the cost?

DR. WODEHOUSE: I think the figure of 80% which was quoted yesterday could not be correct. This I do not believe. You can buy P.S.I. at \$108 a year. A family can buy unlimited coverage which is not beyond the means of 80% of our population. This is just an abstract statement that I just cannot accept.

COMMISSIONER FIRESTONE: You realize, sir, you are dealing only with one question of the health cost. Quite rightly so. As doctors you are concerned with medical care costs. There are other problems as well. There are drug costs, dental care



...the ...
...the ...
...the ...

...the ...
...the ...
...the ...
...the ...
...the ...
...the ...
...the ...

...the ...
...the ...
...the ...
...the ...
...the ...
...the ...
...the ...

...the ...
...the ...
...the ...
...the ...
...the ...
...the ...
...the ...

...the ...
...the ...
...the ...
...the ...
...the ...
...the ...
...the ...



Wodehouse

10143

costs, nursing costs and then these families also have to pay other premiums or taxes and to pay for hospital insurance so that what I understood your colleagues were telling us yesterday that one should look at the health picture as a whole, but my question to you is that very specific question, sir: that whatever that proportion may be, and that is why I commenced my question by saying let's wait until we really have the research results; whether it is 80% or considerably less ---

THE CHAIRMAN: If any researcher tells me it's 80%, I will tell him to go and check his figure.

COMMISSIONER FIRESTONE: Whatever the figure may be.

THE CHAIRMAN: I don't think any one of us is entitled to abrogate our right of exercising some element of common sense in the answers given by doctors, economists, sociologists or lawyers.

COMMISSIONER FIRESTONE: Dr. Wodehouse, my question relates to the problem of people in the middle income group and it has been suggested to us, whether you accept what has been suggested or not, that there are a good many people in that income group that find it difficult to cover all the health costs on a prepayment basis.

Now, the question I am putting to you is: what is the solution to the problem that these people face? Is the solution that they do not get extensive coverage or is the solution they go down to the local welfare officer and undergo a means test? We are now talking about the middle income group.



Wodehouse 10144

THE CHAIRMAN: I think I should add that I did not understand Dr. Rhodes and Dr. Hastings as saying completely what has been suggested. They said, or I understood them to say, having regard to the money we spend in other things; cigarettes, such as you are using now, liquor, cars, etc., etc., that the Canadians ought to be able to pay for full health coverage. That was the real gist of the submission, as I understood it.

DR. WODEHOUSE: Mr. Chairman, could I make another comment? Mr. Firestone, excuse personalities but my friend over there I have listened to with great interest through many of these sessions, always works it around to the almost emotional feeling that everyone has to have insurance. 100% of the population just have to have insurance and pay their costs. This, sir, is not correct.

Insurance is one of the mechanisms of paying costs. There is another way of paying it out of your own pocket. There are a few people who can afford to take the gamble and pay it this way. There are other people who have medical care provided through the armed services, the R.C.M.P. 51,000 in our various institutions, penitentiaries, get their medical care. Now, they are all the people under medical welfare plans.

It has never been stated in our statement of policy that we insist on having 100% of the population having insurance. We have said that we feel that insurance should be available to those people who want to buy it. They do not have to have it. I just



Wodehouse

10145

cannot go along with this kind of view that everyone has to have insurance in order to get by in this world.

COMMISSIONER FIRESTONE: I am referring to this middle income group that it has been suggested to us in many instances, or in some instances, a good many instances, may not be able to pay for such services and my question was: is there anything that can be done, in your opinion, to assist such families in the middle income group.

THE CHAIRMAN: I am sure, Dr. Firestone, we want to be factual. I have no recollection yesterday afternoon of anyone saying that the middle income group - we have always discussed in terms of the lower income group.

DR. WODEHOUSE: This again, sir, depends upon the definition of the middle income.

COMMISSIONER FIRESTONE: It is quite true that we had a very detailed exposition yesterday on this.

THE CHAIRMAN: This is the first time that that expression "middle income group" came forward voluntarily in that sense. It was as a result of questioning from which certain answers logically flowed.

COMMISSIONER FIRESTONE: Well, now, quite right, Mr. Chairman, that we have had very little statements until yesterday on this point.

THE CHAIRMAN: We have had no statements about middle income group until yesterday. It always related to the low income group. What we call the grey area.



Wodehouse

10146

COMMISSIONER FIRESTONE: There may be some definition of where the grey area begins, where the grey area starts, but my question is there may be families in the \$3 to \$6 thousand a year group that find it difficult to pay full medical care service. How are their requirements taken care of?

DR. WODEHOUSE: I think we have outlined, without defining income levels, or other things, people have problems in paying their medical care. If they fall within this low income group, fall within the medically indigent group, they take their problems to a local authority, define their situation and receive appropriate help. I do not think, sir, I can make it clearer than that.

COMMISSIONER FIRESTONE: Fine; and they are provided help on a means basis - on a means test basis?

DR. WODEHOUSE: That is right, sir. No other way of doing it.

COMMISSIONER FIRESTONE: May I now turn to another principle, that is on page 79, No. 1, in which you speak of, and I quote:

"That all persons rendering services are legally qualified physicians and surgeons."

I am wondering whether this phrase could be interpreted broadly, and if my interpretation is not correct, please correct me, to include para-medical personnel serving under doctors' orders and instructions, supervision?



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Wodehouse

10147

DR. WODEHOUSE: This statement also, sir,
refers to medical service insurance. In other words,
doctors' service insurance as we understand it.



K/ss 2

1
2
3
4 DR. WODEHOUSE: We mean exactly what
5 we say when we say a registered physician. We have no
6 leeway. We have persons working under our authority
7 for whom we take legal responsibility who are included
8 in that team. There is a nurse in the allergist's
9 office who gives the needle. If something goes wrong the
10 doctor accepts the responsibility. She is doing it under
11 his supervision. We have nurses in the operating room
12 under our supervision. What we are talking about here
13 is actual doctors' services.

14 COMMISSIONER FIRESTONE: I take it when
15 you use that phrase legally qualified physicians and
16 surgeons you are referring to the services that are
17 provided really by teams under the supervision of legally
18 qualified physicians and surgeons; is that correct, sir?

19 DR. WODEHOUSE: Broadly, yes.

20 COMMISSIONER FIRESTONE: Thank you,
21 sir. We have been told that we may be facing shortages of
22 doctors as a result of increased demand for medical care
23 services. Do you agree that this is the problem?

24 DR. WODEHOUSE: Yes, sir.

25 COMMISSIONER FIRESTONE: Anticipated
26 shortages.

27 DR. WODEHOUSE: I am sure if the committee
28 looks at Appendix A at the back of the book it portrays
29 our feelings on that subject. We graduated 850 doctors,
30 more or less, last year. We estimate that by 1980 we are
going to need 1450. Our schools are, at the moment,
working to their full capacity. A few of them can be
expanded. We feel we need more medical schools to fill the



Wodehouse 10149

gap between 850 and 1450.

COMMISSIONER FIRESTONE: I am wondering, Dr. Wodehouse, whether that is the problem of the doctors, of practising physicians, or whether in part it is not a problem of making more effective use of the professional training of the medical practitioner, and if so, have you any suggestions as to how the output of medical practitioners could be increased still maintaining the high quality of service such as you maintain?

DR. WODEHOUSE: Mr. Chairman, I wonder if Mr. Firestone could explain how we are not using our services efficiently. I am not aware of this problem. Maybe it is.

THE CHAIRMAN: I think the question is all right. Why not face up to it?

DR. WODEHOUSE: I will come back to it. I will say apart from the activities of C.M.A. I don't think I use my time inefficiently.

THE CHAIRMAN: I don't think you are quite as naive as you are in that answer, that you don't know what the discussion is about, about group practice and all this kind of thing. This is what the question involves.

DR. WODEHOUSE: Having made that qualification I will answer it.

THE CHAIRMAN: I think you should have recognized it.

DR. WODEHOUSE: I didn't get that out of the question.

THE CHAIRMAN: Group practice is only



Wodehouse 10151

one. I am not saying it is the whole.

COMMISSIONER FIRESTONE: Group practice and increasing of paramedical personnel.

DR. WODEHOUSE: It is a way of doing it. It is not necessarily the best way. It is a way.

DR. RABSON: May I say this, this is one of the dangers of planning again. People who practise medicine are individuals. When you set down a method of increasing the output of its members you might apply it to some, but not to others.

THE CHAIRMAN: Nobody is suggesting you should.

DR. WODEHOUSE: Mr. Firestone asked if there was some way the output of doctors could be increased. Certainly paramedical personnel is one method.

THE CHAIRMAN: He didn't ask for one method, he asked for the views of you distinguished gentlemen.

DR. WODEHOUSE: I cannot find the appropriate paragraph here. Perhaps Dr. Kelly could look it up while I am talking in general. One difficulty with group practice, if that is your question, doctors are individuals. They have to be individuals to carry on the type of life and type of responsibilities that they meet day to day among their practices. Some doctors like to work as sole practitioners, and by their personalities don't fit in well with a organized group. Many other doctors find a community support in formally, officially organized groups very satisfying. I myself work in this City as a so-called sole practitioner. I don't feel I am



one, I am not sure it is the whole.

and necessarily or get medical personnel.

it, it is not necessarily the best way, it is a way.

one of the dangers of thinking again, people who practice

medicine and in medicine, it is a way down a method of

increasing the output of the machine you might say it is

some, but not to others.

THE CHAIRMAN: Nobody is suggesting

you are not.

A. W. WATKINS: Mr. Chairman, would it

there was some way the output of doctors could be increased.

certainly practical personnel is one method.

THE CHAIRMAN: He didn't ask for one

method, he asked for the idea of one distinguished

method.

MR. WATKINS: I cannot find the

appropriate paragraph here, because he really could look

it up where I am talking in general, but difficult with

general practice, it is in your question, doctors and

individuals, they have to be individuals to carry on the

type of life and type of responsibilities that they

must carry to carry out their processes, some doctors like

to work as sole practitioners, and by their personalities

which it is well known a specialized group. Many others

others like a group with a group in which they are

organized groups very different. I would work in this

for a long time as a physician, I would not I am



Wodehouse 10152

1
2
3
4 on my own. I have a group of my colleagues around me to
5 whom I can refer directly, indirectly, by telephone, in
6 person, and from whom I get very adequate support under
7 all conditions. It doesn't require formalization of this
8 association. It is a working arrangement between a group
9 of persons who know each other. When we get group
10 practice, it is almost always by the efforts of some
11 man of personality and force who has collected around him
12 a few people who like working with him and get along
13 together as a team. In many areas they develop certain
14 formalized groups representing some specialties, represent-
15 ing whatever specialties they can get in the area.
16 That is efficient in that area. It does not necessarily
17 apply everywhere. Doctors operate in many different ways
18 and they should be permitted to do so. It is in Paragraph
19 34, Page 12.

20
21 THE CHAIRMAN: What is involved in a
22 city in Toronto, whether you like to practise in a group
23 or solely is of absolutely no significance, but we have
24 the whole hinterland of Canada to consider as well.

25 DR. WODEHOUSE: I agree with that.

26 THE CHAIRMAN: Now, would you accept
27 that, perhaps, some of this rugged individuality might
28 be submerged for the common good, to provide services in
29 areas where that may be the only way?

30 DR. WODEHOUSE: We have a sentence in
here.

THE CHAIRMAN: It is the principle.
We are not concerned about whether Doctor A will not get
along with Doctor B. We are trying to see if in a



Wodehouse 10153

developing situation the teamwork principle of medical practice, there could be found some way whereby the isolated areas of Canada may be served in some degree comparable to how the larger urban areas are served. We know we can't give the same service in Lake Athabaska as we give in Toronto, but are we to be prevented from trying to canvass the situation and get a judgment of you men who are in charge of the medical profession in Canada.

DR. WODEHOUSE: Mr. Chairman, we have many comments to make on this subject. The one most easily accessible is on Page 11 of our summary and recommendations. It states: The use of subsidy by public funds to increase the location of a physician in areas otherwise unable to attract a doctor is recommended. Mr. Chairman, if there is an area where a group of physicians would serve that community better I am sure we as an Association would be in favour of a subsidy for that group if that is what is applicable in that area to provide services.

THE CHAIRMAN: Would you go further and say it should be part of medical education, that this information ought to permeate through your medical education?

DR. WODEHOUSE: Not necessarily, sir.

THE CHAIRMAN: Or training at some time.

DR. WODEHOUSE: Not necessarily.

THE CHAIRMAN: That the team approach to the practise of medicine ought to be the one rather than this rugged individualist with his black bag.



Wodehouse 10154

1
2
3
4 DR. WODEHOUSE: Mr. Chairman, if I
5 might make this comment, team approach is a concept of
6 all our training. No one can go to the University of
7 Toronto or interne in any of our teaching hospitals with-
8 out recognizing he is a member of a team, whether he is
9 a member of a formalized organized medical staff in a
10 teaching unit or a staff in a hospital, or as a graduate
11 practising member of the Cardiovascular Unit with all the
12 paramedical personnel there -- this is teamwork. This is
not a new concept you are putting forward.

13 THE CHAIRMAN: Can you see yourself
14 thinking a little further and carrying that beyond the
15 confines of Toronto?

16 DR. WODEHOUSE: Sir, I think this
17 education which is going on, if this is what you mean --
18 I am not a member of a formalized team. I am a doctor in
19 this large centre of medicine of Toronto where there are
20 many, many doctors. This concept of consultation, mutual
21 support, even formal business arrangements can be applied
22 usefully where the people are willing to do it, and
where the need is present. As far as the concept is
concerned, who is going to teach that concept?

23 THE CHAIRMAN: In the isolated areas.
24 I think you are a little too touchy, gentlemen.

25 DR. WODEHOUSE: I said I would go along
26 with that.

27 COMMISSIONER FIRESTONE: Does the
28 Canadian Medical Association, Dr. Wodehouse, endorse
29 group practice?

30 DR. WODEHOUSE: They endorse it as one



...might mean this or that, I am afraid it is a concept of
 all one thing. No one can go to the university of
 Toronto or elsewhere in order to be teaching history with
 out recognizing it is a matter of a text, whether he is
 a teacher or a student or a research worker. It is a
 teaching unit or a staff in a hospital, or as a graduate
 teaching member of the University of Toronto. It is all the
 same. This is the same as the same. This is the same as the same.
 ...a new concept you are putting forward.

"W. G. ... I am not sure you see what I mean.
 ...a little further and away; that beyond the
 ...of ..."

...I think this
 education which is going on, it is this is what you mean --
 I am not a member of a formalized team. I am a doctor in
 this large center of radiation of Toronto where there are
 many, many doctors. The concept of consultation, mutual
 support, even formal and informal engagements can be very
 useful where the people are willing to do it, and
 where it is needed. As far as the concept is
 concerned, who is going to teach that concept?

...in the ...
 I think you are a little too ready, gentlemen.
 ...I said I will ...

...the
 ...Mr. Woodhouse, ...
 ...they ...



Wodehouse 10155

method of practising.

COMMISSIONER FIRESTONE: Have you done anything to assist people or physicians wanting to establish themselves in group practice in providing information as to how they can go about it?

DR. WODEHOUSE: You are asking about group practice --- we have a seminar that is available to all graduates where they are lectured by all ranges of specialties -- I presume it is still going on --- including group practice, pointing out the benefits or otherwise, attractions or otherwise. As far as someone seeking information is concerned I know that in Ontario, the Ontario Medical Welfare Association does have information, statistical documentary information available suggesting types of agreements, contracts, limitations, methods of setup. It is all present, sir. We don't sell it with individual salesmanship. It is there.

COMMISSIONER FIRESTONE: In other words, if a group of doctors wished to set themselves up in practice...

DR. WODEHOUSE: We would be glad to give them advice.

COMMISSIONER FIRESTONE: The Ontario Medical Association or C.M.A.

DR. WODEHOUSE: It is a Provincial matter, sir, primarily.

COMMISSIONER FIRESTONE: You have left it to the Provincial Association.

DR. McMILLAN: There is an association of people concerned with group practice and doctors who



10-1-53

of specialists.

Q. Now, have you had any

anything to assist people or in this way?

Q. Now, have you had any

information as to how they can go about it?

A. Yes, I have. You are asking about

group practice -- we have a seminar that is available

to all graduates where they are lectured by all members

of specialists -- I presume it is still going on --

including group practice, pointing out the benefits of

otherwise, in the lines of otherwise, as far as someone

asking information is concerned I know that in Ontario,

the Ontario Medical Welfare Association does have infor-

mation, statistical documents, information available

suggesting types of agreements, contracts, limitations,

methods of action, it is all present, sir. We don't

sell it with individual subscription. It is there.

Q. Now, if a group of doctors wished to set themselves up in

A. Yes, I would be glad to

give them advice.

Q. Now, I am interested in the Ontario

Medical Association or C.M.A.

A. Yes, I would be glad to

Q. Now, I am interested in the Ontario

Medical Association or C.M.A.

A. Yes, I would be glad to

of course can work with group practice and doctors who



McMillan 10156

look for information generally go to this particular group for the information.

DR. WODEHOUSE: There is a publication called Group Practice and a series of information available to that effect.

COMMISSIONER VAN WART: Might I bring up one point about group practice, it is in Section 34, your last sentence: "The Courts have ruled that medicine may not be practised by corporations, but only by registered medical practitioners who, as individuals have professional responsibilities toward their patients". Can you enlighten us, Dr. Kelly, of the Court decisions?

DR. KELLY: That refers to a ruling made five years ago in the Supreme Court of Ontario on an action by a doctor who had severed his connection with a group practice in an Ontario city. The Judge in making his ruling, made it very clear, spelled it out, that a clinic, a corporation could not itself practise medicine and it was a requirement of the law of this Province that an individual registered medical practitioner practise it.

THE CHAIRMAN: That is merely an interpretation of the provisions of the Ontario Medical Act.

DR. KELLY: Right.

COMMISSIONER FIRESTONE: Dr. Wodehouse, if I may draw your attention to another subject altogether: May we turn to Paragraph 13 on Page 80 of the principal submission, and I quote: "That members of the medical profession, as the providers of medical services, have



Wodehouse 10157

the right to determine the method of their remuneration".
Is the method of remuneration which you recommend, which
you endorse as a desirable one a fee for service method?

DR. WODEHOUSE: We have commented on
this in our initial document, the characteristics of the
medical profession, and again we have commented here.
We have said for the ordinary practise of medicine fee
for service is the most acceptable method to the doctor,
and we presume, by experience also to the patient. We
have also pointed out that some of our physicians in
particular circumstances are quite well paid by salary.
We have also pointed out some are paid on a so-called
sessional arrangement, persons working for D.V.A. We pointed out
for example, with myself, a mixture of these methods is
perfectly applicable. Our preference for ordinary
practice is fee for service.

COMMISSIONER FIRESTONE: If this fee
for service method is, as you say, acceptable and prefer-
able in many instances, how does the C.M.A. feel about
the payment for such services being made directly by the
insurance carrier to the participating physician?

DR. WODEHOUSE: This, again, is some-
thing that is developing. We have to admit that payments
are made in many instances directly to the doctor. That
has been an acceptable method. It really depends on who
the insurance agent is, what authority they have, what
is the legal ability to control and so on that is
applicable. If one is able, working under free conditions
where one has a variety of methods of making ones living,
and a variety of methods of receiving payment it is an



Wodehouse 10158

acceptable method. If the only method of being paid is this one by someone who has legal powers to say this is the way it will be done, then it is completely unacceptable.

COMMISSIONER FIRESTONE: As I understand it from what you are saying C.M.A. considers direct payment by the insurance agent to the physician as an acceptable method and that, in fact, is the case in many instances. As far as you know, sir, this method of payment has not affected the quality of medical care?

DR. WODEHOUSE: That is right, sir.

COMMISSIONER FIRESTONE: My last question, sir, is concerned with the requirement for a medical health care plan in Canada. Each Commissioner gets different impressions as they listen to different submissions, and therefore I don't want to speak for any of my fellow Commissioners.

Giving you my personal impressions, listening to farm groups, and labour groups, and many people who speak for the consumer, there seems to be a view developing that there is need in Canada for what, for lack of a better phrase, is described as a national health plan for Canada. Do you feel, sir, that the proposals contained in your brief represent the elements of such a national health care plan that the people in Canada demand?

DR. WODEHOUSE: Mr. Chairman, this is the national health care plan which the Canadian Medical Association recommends for the people of Canada.

COMMISSIONER FIRESTONE: Thank you



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

Wodehouse 10159

very much, sir, to you Doctor Wodehouse and your colleagues.
You have been very kind and patient to me.

THE CHAIRMAN: Now, gentlemen, if you will
extend that kindness and the patience, we would like you
to come back at two o'clock.

We will rise until two o'clock.

---Luncheon Adjournment.



--- On resuming at 2 p.m.

THE CHAIRMAN: Ladies and gentlemen, if we may proceed. There are just a few items upon which we might have a little more information. At the top of page 8, Recommendation No. 15:

"That approved carriers of medical services insurance be selected from the plans now operating ---"

What significance is there to the use of the word "now" as restricting any new ones?

DR. WODEHOUSE: There is no real intention of restriction. There are plans operating now. We think if you are going to put in a mechanism soon this is the way to do it. If there are other carriers in the future who meet the needs, there is no restriction.

THE CHAIRMAN: The next is on page 9, sub-section (e):

"The qualifications of all doctors appointed to the Indian and Northern Health Service be registerable."

Would you expand on that, and tell us what is involved here?

DR. WODEHOUSE: We have had one or two instances where Indian Affairs and Northern Affairs and so on have had difficulty in getting practitioners to go to very remote areas, and failing the attraction of the terms of employment and the facilities offered to them, they have been unable to get Canadian doctors to fill these posts and a few times in the past they have reached out and procured the services of a doctor



Wodehouse

10160

in another country, who would not meet our ordinary standards, and they have employed these persons in the limited areas of the Indian and Northern Health Services. We feel this is wrong in general principle. I think the attack should be the other way. Make the conditions of employment sufficiently attractive that you get good young, well-qualified, well-registerable physicians from Canadian sources to go into these remote areas. Even if you get the youngsters to go in for two, three, or five-year periods on a rotational basis.

THE CHAIRMAN: What happens to these people, supposing they are brought in and go to the northern areas and don't like the climate?

DR. WODEHOUSE: There are not too many of them there, sir. They have the chance of coming down and meeting our requirements for registration and passing our examinations. There is no restriction to keep them out of the country, any more than any other doctor.

THE CHAIRMAN: That is not what I had in mind. I was just wondering if it presented a problem?

DR. WODEHOUSE: No, I don't think so, sir. I don't know that, I don't think so.

THE CHAIRMAN: On page 10, Recommendation 19(b):

"An authoritative information service on all new drugs."

Just what have you in mind here that is not being done? Nothing may now be being done for all I know.

DR. WODEHOUSE: We should consider (a)



Wodehouse

10161

and (b) together. (a) refers to the use of the so-called generic names, and you have heard a great deal in the presentations of our pharmaceutical friends, and in some cases by our professional associations about the advantages or disadvantages, or theoretical advantages, of the use of generic names.

Getting at it from a practising physician's point of view raises the problem in that when you write something by generic name, we have at the moment no guarantee that we are going to get the potency, the safety, and all the precautionary methods used by using the generic name off the shelf, whereas if we go to some of the straight trade names, put out by the authorized, recognized, well-established drug companies we know that these safety mechanisms are built in. We know that we are going to get proper potency, proper safety, and what we want, and therefore, sir, we are a little bit on the fence.

Theoretically, we quite see the benefit of the use of generic names, but at the moment we cannot see the guarantees built in.

Going back to the reason for all this, our Food and Drug Department in Ottawa, which is excellent and works its head off, and really applies all of the safety factors which anyone could hope for in view of their budget and resources; for them to apply, we feel there should be some guarantee for all drugs appearing under generic names, that these drugs meet the requirements.

THE CHAIRMAN: What form would this



Wodehouse

10162

authoritative information service take?

DR. WODEHOUSE: I would say circulars to the doctors.

THE CHAIRMAN: From the Food and Drug ---

DR. WODEHOUSE: Yes, sir.

DR. RABSON: I think we have to confess that in Canada our food and drug control is inadequate. We employ approximately 300 people on a budget of about \$300,000, whereas in the United States their budget is some millions. We have recently had some very dangerous drugs released on the market and it seems to us that in spite of the size of the country we still have to examine the same number of drugs.

THE CHAIRMAN: How do these drugs get in circulation? I thought all drugs came through a physician's prescription?

DR. WODEHOUSE: For example, the one that has had its publicity recently; it is a sedative which was put out and passed the regulations of quality and of potency, but in humans there had been no opportunity to study its defects and there actually, in the case of that instance, hadn't been studies in the case of animals. Whether this is possible to put into effect with every new drug, I don't know either. There would doubtless be new drugs come out to meet these standards, which would be dangerous in later years. This has happened before, but we feel there should be more of an effort to do this on a national basis, particularly if we are going to do away with the trade names and use the chemical name.



Dr. WOODHULL: I don't see circumstances

from the food and drug --

Dr. WOODHULL: Yes, sir.

Dr. WOODHULL: I think we have to consider

that in certain our food and drug control is inadequate. I don't think we have a budget of about \$30,000,000, whereas in the United States their budget is some \$100,000,000. We have recently had some very dangerous drugs introduced on the market and it seems to me that in spite of the size of the country we still have to examine the same number of drugs.

Dr. WOODHULL: How do these drugs get

in circulation? I thought all drugs came through a

physician's prescription?

Dr. WOODHULL: For example, the one

that has had its publicity recently; it is a relative which was put out and passed the regulations of quality and of potency, but in human there had been no opportunity to study its effects and there actually, in the case of that one, didn't have studies in the case of animals. Whether this is possible to put into effect and every new drug, I don't know either. There would doubtless be new laws come out to meet these circumstances, which would be dangerous in later years. This has

been a problem, but we feel there should be more of a effort to do this on a national basis, particularly in the case of going to the drug and the side effects and use the



Wodehouse 10163

The laboratories can do chemical tests and animal experiments. They cannot do human experiments except in co-operation with the clinical facilities of hospitals. There are very, very few hospitals who have qualified staff in the way of medical ability, statistical ability, experimental controls and so on, who are qualified to really run these assays and experiments and they are burdened by many, many requests to assess the value of drugs.

We feel that along with these programs under (a) and (b), part of the program again is to encourage more active co-operation between the various centres to promote controlled experiments of new drugs on human patients, so that after a period of proper control the central authority can say, this drug, in our opinion, is a good drug, or this drug has been tried and is no use or is dangerous or hazardous.

THE CHAIRMAN: Has the Canadian Medical Association any opinion to offer on the recent Alberta legislation dealing with authorizing druggists to fill a prescription by generic name?

DR. WODEHOUSE: Sir, we have no Association opinion as yet, but it is too recent for us to have an Association opinion. In my own personal opinion I think it is a very dangerous piece of legislation.

THE CHAIRMAN: Do you know if the Alberta Medical Association or the College of Physicians and Surgeons protested against this, or submitted any ---

DR. WODEHOUSE: No, I don't know. I see Dr. Bramley-Moore sitting here.



Bramley-Moore 10164

DR. W. BRAMLEY-MOORE: Mr. Chairman, the Council of the Alberta College considered the legislation before it was passed, and in the way it was worded we felt the patient would have every protection from the doctor, who was fully aware of what he was prescribing.

THE CHAIRMAN: I suppose it has not been in force long enough to get any experience in its working, in a practical way?

DR. BRAMLEY-MOORE: No, sir, it has not, but we do not perceive any particular problem in this respect.

DR. WODEHOUSE: As an Ontario physician, I would feel if a similar law were applied in Ontario that this places responsibility upon the druggist. It is up to the druggist to determine whether his generic name on this shelf is as good, as safe, and as potent, as his well-established trade name on this shelf.

THE CHAIRMAN: Why should that be beyond the competency of the well-trained druggist, or pharmacist?

DR. WODEHOUSE: Well sir, if something comes from well-known houses, such as Parke-Davis, or Horner, houses we know did have these built-in factors of safety control. If something comes from a country outside of Canada, we don't know what the factory was like, whether the safety factors have been paid attention to. There is no mechanism at the moment which will guarantee these things to us.

THE CHAIRMAN: How does the doctor know



Wodehouse

10165

it in the first place?

DR. WODEHOUSE: Well, sir, I named a few reputable drug companies and I know on certain trade names that these I know are good.

THE CHAIRMAN: Well now, we hear that it is the practice of the drug industry to have detailmen, as they are called, circulating throughout the country in considerable numbers, and the justification for them is that it is these detailmen, who are qualified druggists, who are instructing the doctors in the use of the drugs. Is this system of detailmen for the instruction of doctors necessary?



DR. QUINTIN: I would like to rise and protest that.

THE CHAIRMAN: Protest what, the question or the practice?

DR. QUINTIN: That the detailmen are instructing doctors. This would be a case of wisdom being fed by brutish beasts as far as I am concerned. I think, speaking for a local area, that perhaps no more than 40% of the detailmen are trained pharmacists any more because it is very difficult to obtain trained pharmacists. I hope the profession never reaches the stage where they have to depend on their pharmaceutical knowledge from detailmen.

THE CHAIRMAN: I have the figures for Canada but I have not got them in front of me but they are smaller than the American figures that I am going to give you now. The information we have is that there is in the United States some 15,000 detailmen mostly pharmacists whose duty it is visit doctors continuously to the extent that there is one for every ten physicians practising in the United States.

DR. McMILLAN: They have other duties, they go to the hospitals and the pharmacists, they also sell to the other pharmacists and it is only part of their job to visit the doctors.

DR. WODEHOUSE: I think if we can check with the detailmen ---

THE CHAIRMAN: When we get figures it is less in Canada but it is still a very large figure. I am told these detailmen call very frequently on practising doctors and they tell us that they educate



DR. WINTER: I would like to raise another question.

DR. WINTER:

THE CHAIRMAN: I repeat what, the

question of the doctor?

DR. WINTER: What the doctor has

mentioned doctor. This would be a case of wisdom being led by heart's desire as far as I am concerned. I think, especially for a small group, that perhaps no more than six of the best men are trained pharmacists any more because it is very difficult to obtain trained pharmacists. I hope the profession never reaches the stage where they have to depend on their pharmaceutical knowledge for their lives.

THE CHAIRMAN: I have the pleasure

for Canada but I have not got them in front of me but they are earlier than the American figures that I am going to give you now. The information we have is that there is in the United States some 12,000 doctors mostly specialists whose duty it is visit doctors continuously to the extent that there is one for every ten physicians practicing in the United States.

DR. McLELLAN: They have other duties,

that is to the hospital and the pharmacist, they also call on the other party and it is only part of their job to visit the doctors.

DR. WINTER: I think if we can

check with the chairman --

THE CHAIRMAN: When we get figures it

is in fact that it is still a very large figure. I am told these figures are very low. I am told these figures are very low and they tell us that they are



Wodehouse

10167

the doctors.

DR. McMILLAN: With regard to the question, we talk to these men on research done by their company and they may provide us with brochures from medical journals which you can read yourself as to the type of research which has been done to establish the safety and potency so in this sense I guess it could be called an educational program.

DR. WODEHOUSE: I think the type of detailer depends on the area of practice, on the type of practitioner. If the practitioner is carrying a very heavy work load he may look on this as an easy way of catching up on the new drugs being put out. In my own experience, this is not for or against detailmen but I see very few detailmen and only those who come from the reputable companies. I only see them if they can tell me something about a new drug -- I do not want to hear about the latest mixture of aspirin and phenobarb in different quantities -- if they have a penicillin or one of the myecins I want to hear about that and he will leave me literature. This serves a very useful purpose. As far as I personally am concerned, they do not educate me on how to mix aspirin and phenobarb.

COMMISSIONER McCUTCHEON: They leave you samples?

DR. WODEHOUSE: No, they stopped doing that since I stopped seeing them. They still mail them, though.

THE CHAIRMAN: Oh well, they do not leave any for me because I do not see them either.



1
2
3
4 And now, about the samples: Is it
5 a fair statement that they made to us there is a great
6 volume of samples left with practising doctors in
7 Canada?

8 DR. WODEHOUSE: In great volume maybe
9 by direct mail advertising as well. In my practice,
10 and I am speaking for myself, my secretary, if it is
11 something good, I'll put it in a drawer and it may be
12 useful for one of my patients who cannot afford to pay
13 for it but the rest of them go in the waste basket.

14 THE CHAIRMAN: Have you advice to give
15 as to this practise, of this very large practise, of
16 filling up the doctor's office with samples?

17 DR. WODEHOUSE: We have had conversa-
18 tions with our friends in the Pharmaceutical Association
19 and I mean literally our friends because they are very
20 co-operative and very useful. They tell us this is a
21 matter, with their business experience they still feel
22 there is value in direct mail and the detailmen. This
23 is the business aspect, I suppose.

24 THE CHAIRMAN: And the volume of
25 samples?

26 DR. WODEHOUSE: Yes, we feel the better
27 approach would be through the medical journals and we
28 are setting up at the moment the standard of accredita-
29 tion.

30 THE CHAIRMAN: It is said that some
drug prices are high and that the price of drugs is a
very serious element in the health care costs. There is
the matter of the detailmen, this mail material, the



1
2
3 volume of samples, naturally this is all in the cost
4 of the drug that reaches the public. Now, you are
5 living with the condition from one end of Canada to the
6 other, do you think it should continue or have you any
7 views to offer?

8 DR. KELLY: You have asked if the
9 C.M.A. had done anything to mitigate the promotional
10 activities of drug houses and the answer is yes, we
11 have protested the volume of direct mail to us. We
12 feel in this highly competitive field of pharmacy that
13 it is being over-promoted. We have asked that they
14 be selective in their direct mailing. In respect to
15 sampling we have one other contact with the pharmaceutical
16 industry and that is in respect to the exhibits for the
17 annual meeting of the Canadian Medical Association.
18 For the past five years we have, by arrangement with
19 the Medical Exhibitors Association, made it impossible
20 for them to distribute samples at such exhibits. We
21 have said that if a doctor wants to try out a product
22 you are entitled to send it to him if he asks for it
23 in writing but we discourage the distribution of printed
24 literature and in particular the samples.

25 DR. McMILLAN: In discussing this
26 with the drug people, they tell us their industry is
27 like any other industry, it sets aside a certain amount
28 of money for advertising and there is this drug
29 advertising in the journals and samples and one thing and
30 another they are within the average normal budget of
a comparable business and discontinuance of any of these
things would not directly affect the drugs to any great



Wodehouse

10170

1
2
3
4 extent. I have no way of inducing means to these
5 people but those people who induce the advertising
6 cost of businesses of various types probably could
7 answer that.

8 THE CHAIRMAN: I am not objecting to
9 what you have said but we are not asking for the defence
10 of the drug companies we are asking for the views of
11 the medical profession on what is going on with drugs.

12 DR. WODEHOUSE: I think we can say
13 quite definitely we would favour further advertising
14 and publicity to get drugs through our recognized
15 medical journals and we could develop a system which
16 we are presently evolving in the Canadian Medical
17 Association Journal where information could be gathered
18 as to drug safety and potency, et cetera.

19 THE CHAIRMAN: Now, working into --

20 DR. WODEHOUSE: Could I make a comment
21 about number 20? There has been a great deal of enquiry
22 about the cost of drugs in this country and the cost
23 of drugs to the patient. We have recommended there that
24 the Federal Sales Tax of 11% be eliminated. Actually
25 the sales tax on drugs means a lot more than that by
26 the time it passes through sales tax and provincial
27 taxation and so on and sometimes it approaches 20% to
28 25% before the drug is passed on to the patient in a
29 prescription. I think for the government or others that
30 are interested in reducing the price of drugs there is
one very practical way of doing it.

COMMISSIONER McCUTCHEON: You refer
to your difficulty in knowing whether the generic drug



Wodehouse

10171

1
2
3
4 has the same quality or potency as the drug under a
5 trade mark name and you refer to these drugs as being
6 imported and so on. Going back to your recommendation 19a,
7 that control that you visualize which would give you
8 this confidence that you require, would really mean
9 testing every batch of drugs that came into the country?

10 DR. WODEHOUSE: No sir, not entirely.
11 If you had a food drug bureau who had an adequate
12 group of qualified inspectors who knew all the answers
13 it would be easy for them to go into some of the
14 reputable drug houses and to recognize that these things
15 are being done and there is no further testing needed
16 of those products. However, they meet some brand new
17 company which is not established and which they do not
18 know and they may well find their practice regarding
19 safety and potency and testing would be completely
20 inadequate. They would have two alternatives, to do
21 the testing themselves or meet a certain standard of
22 efficiency and consistent standards of behaviour or they
23 could not sell drugs. This is all we are talking about
24 there, it does not mean the individual testing of every
25 drug by any means.

26 COMMISSIONER McCUTCHEON: Really you
27 are saying a part would rely on what you call a reputable
28 drug house to do the testing and quality control in
29 accordance with the conditions it may lay down, is that
30 it?

DR. WODEHOUSE: No, not necessarily.
Any drug house should do the testing and ensure that the
test is being done and in any doubtful instances they



Wodehouse

10172

1
2
3
4 should test this. It goes both ways, they would have
5 a drug branch and they would come in and find out about
6 it.

7 COMMISSIONER McCUTCHEON: Suppose I
8 bring in a drug that requires no further processing
9 whatever, where is the testing to be done? That would
10 have to be decided on a different approach?

11 DR. WODEHOUSE: Yes. There are other
12 in-built features about control of drugs, the shelf
13 life of a drug. We know, for instance, that our reputable
14 firms do not permit a drug left on a shelf beyond a
15 certain time and they will come around perhaps every two
16 years and replace them with current fresh stock. That
17 happens with the reputable companies but we have no
18 such guarantee with the smaller companies.

19 COMMISSIONER McCUTCHEON: I suppose
20 if a pharmacist was to import drugs directly you would
21 not know whether he had done that two years ago?

22 DR. WODEHOUSE: No, we would not.

23 THE CHAIRMAN: At the top of page 10,
24 the arrangement for financing of the Departments of
25 Radiology and Pathology related to their work loads and
26 administer their cost by separate financing. Just
27 what is involved in this recommendation?

28 DR. WODEHOUSE: Well, originally when
29 the Hospital Insurance and Diagnostic Services Act was
30 in its birth it was recommended by the Canadian Medical
Association that the payment for professional services
should be kept separate from the more clearly defined
hospital aspect of the insurance scheme. In spite of



Wodehouse

10173

our recommendations in this respect both pathologists and radiologists, to some extent a few other specialists were left in within the framework of the Hospital Insurance and Diagnostic Services Act. The next thing that came about was how to pay these persons for their services and how to maintain a standard of equipment, a standard of personnel, the numbers of personnel of the various departments and this has been handled well in some areas and poorly in other areas. It has gone in an evolution, this method of admission of radiologists and pathologists, many of them have been paid on salary, many on a fee-for-service basis and I do not mean fifty cents for each blood count but related to the volume of work on some basis. Many have been paid on salary without any relationship to the volume of work. We have a few instances in Canada where the salaries were too low to attract the best of people and has discouraged extension of the services available to the public. For instance, the increasing out-patient services, the work load is too difficult for the person to handle, there was little preparation made for hiring of new help and the whole program suffered from overwork and underpay.

THE CHAIRMAN: That would go to the budget rather than than the method?

DR. WODEHOUSE: To the budget rather than the method but the method relies on the budget and I feel these departments could relate the payment to the department on the basis of the work load done in the department and make it rather attractive.



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Wodehouse

10174

THE CHAIRMAN: Just paying on a unit basis or some other basis, you have only so much money for the department?

DR. WODEHOUSE: There is X dollars for the department and to double the work load you make things so that the work is not so good because they are overworked.



Wodehouse

10175

THE CHAIRMAN: Really the problem is proper financing?

DR. WODEHOUSE: Yes, that is true. This is our way of approaching the problem related to the workload.

In the Department of Radiology and Pathology, for example, one needs new equipment. We do not like to have a new microscope budgeted in with a can of paint for the bedroom down the hall. We think that the money should be there for the new microscope and we feel it can be assured if the departmental income is related to the work actually done.

THE CHAIRMAN: Looking into another area altogether, we have had representations from people in the para-medical field, from the, you might call, other practitioners, osteopaths, chiropractors, podiatrists, so forth. What is the recommendation, if any, of the Canadian Medical Association, as to the recognition, and extension of recognition to these professions in terms of medical care in a group society?

DR. WODEHOUSE: Well, sir, it is our belief that the medical profession applies the highest standard of care available in this country; that we have adequate safeguards built in to ensure that standard of care. In our statement of policy, sir, it is our statement that medical care services should be rendered only by medically-recognized and licensed practitioners.

THE CHAIRMAN: Now, dealing with specifically, the osteopathic physicians, do you accept that they are admitted to practise in many States of the United States, and admitted to practise in hospitals in



100-100000-100000

Q. Now, the problem is

to get financing.

A. Yes, that is true. This is

the way of approaching the problem related to the work of

the Department of Health and Education.

For example, we have a situation. We do not like

to have a new situation which is a kind of barrier

for the profession. We think that the way

should be there for the new profession and we feel it

can be handled if the departmental work is related to

the work actually done.

Q. Now, looking into another

area of medicine, we have had representations from people

in the non-medical field, for example, you might call, other

professions, engineers, architects, dentists,

so forth. What is the recommendation, if any, of the

American Medical Association, as to the recognition

and extension of recognition to these professions in

terms of medical care in a group setting?

A. Well, yes, it is one

belief that the medical profession should be right

standard of care available in this country; that we have

to take advantage of the fact that we have that standard

of care. In our statement of policy, we are one

statement that medical care services should be provided

only by trained and licensed personnel.

Q. Now, when you are dealing with

physicians, the category of physicians, do you accept that

they are authorized to practice in any part of the

country and that the practice is legitimate?



Wodehouse

10176

those States?

DR. WODEHOUSE: I accept this applies in some States, but this was subject to a study which was carried out by the Ontario Medical Association and the study covered three aspects, osteopaths, chiropractors and I forget the other one.

It traced the history of osteopaths and there was found some areas where even though they are now recognized they have been trying in the past few years in some areas in the United States to discard these fallacious people and to bring this much more in line with medical curricula, and they have come much more in line with medical curricula.

Our point, sir, is we recognize medical curricula is better health service. Why don't they start out and be doctors? Why insist on applying this outdated, outmoded philosophy?

THE CHAIRMAN: You say you had a Committee make a report. Would that report be available? Might it be made available?

DR. WODEHOUSE: I am sure it could be made available to you.

COMMISSIONER BALTZAN: Mr. Chairman, there is very little left for me to say. The questions I had in mind have already come up. Picking up the point that you just left off, allied practice, I would like to enquire in respect to a statement by Dr. J.V.V. Nicholls, Associate Professor of Ophthalmology at McGill University.

You may have heard this statement and



1
2
3 the statistics. I will read the statistics.

4 "596 patients who had walked into
5 several doctors' offices in the
6 West and the Maritimes, of these
7 38% came for specific eye disease
8 and 62% ostensibly to get glasses.
9 Of the 62%, 45% turned out to have
10 eye diseases; 13% had general
11 disease affecting their eyes and
12 only about 43% just needed glasses."

13 There is some question about some of
14 these people going to the wrong places for their eye
15 troubles. A question put to the Dean of Optometry -
16 question number one was: were the optometrists being
17 trained to recognize ocular pathologies and unequivocally
18 he said yes.

19 A second question was put to him: do
20 the optometrists receive a course in relation to ocular
21 disease of a systemic order and again his answer was yes.

22 The problem before us is here we have
23 a statement to the effect that these people are trained
24 to recognize these things, which they said when recognized
25 are referred to the physicians and one has to balance the
26 assumption of the ophthalmologist versus these statements
27 on the part of the optometrists and it leaves a very wide
28 margin of some difference in that regard and that,
29 coupled with one other aspect, that service, apparently,
30 is in demand by the public.

I felt that by presenting you with what
seems like a dilemma.



the station, I will read the station.

"The patients who have walked into
 several doctors' offices in the
 last and the last, of these
 for some for specific eye disease
 and for some for not disease.
 of the eye, and found out to have
 the disease; 178 had normal
 disease affecting their eyes and
 only about 483 had normal disease."
 There is some question about that of
 these people going to the wrong places for their eye
 trouble, a question put to the Dean of Ophthalmology -
 question number one was: were the ophthalmologists being
 trained to recognize certain pathologies and unrecognizably
 as this was.

The first question was put to him: do
 the ophthalmologists receive a course in relation to certain
 disease of a systemic origin, and again his answer was yes.
 The problem before us is how we have
 a statement as to the effect that these people are making
 to recognize these things, which they said when recognized
 was referred to the physician and one of the things the
 recognition of the ophthalmologist versus the statements
 on the part of the ophthalmologist and it leaves a very wide
 margin of some difference in that regard and that,
 compared with one aspect, that is, the ophthalmologist,
 as a statement by the ophthalmologist.

I feel that by measuring the effect of
 these things is a difference.



Wodehouse

10178

DR. WODEHOUSE: I think I have to interpret the question. I recognize that it is a dilemma. A great deal, I am sure, depends upon the optometrist. There are undoubtedly some schools of optometry where these conditions of training and the recognition of something abnormal pertain, and there are undoubtedly optometrists in this city and others who recognize there is something wrong other than just refraction error and do refer patients, quite ethically and properly, to an eye doctor.

I recognize again there are few areas in this country where there are optometrists who have not these recognized levels of training. Some of them, I don't want to be slanderous, I don't want to use the term "mail order" in its literal sense, but almost on that degree. These, sir, are the people who cause us concern. Very poorly qualified level of optometrist who really causes trouble.

I have to recognize there are many good optometrists who can test my eyes or your eyes and who might, if I had other ocular disease, recognize it and send me for treatment.

I think you will have to recognize I take a great risk in the City of Montreal if I just walk in whether I would get that same level of treatment with any optometrist who had his sign out on the door.

COMMISSIONER BALTZAN: You do recognize these people who are apt to attain proper training. There is another question. Are these people who are deficient - in answer to that; I think that question was



Wodehouse

10179

also put - they assured us that these people now who come to register in Canadian provinces are being examined and only those who qualify may practise optometry. They did tell us, too, there is a certain residuum of the older chaps, dating back to the year 1920, etc., that they still continue to practise but all new registrants coming under their new ---

DR. WODEHOUSE: Specifically, this is an area in which I am not familiar. I think if these gentlemen say they do so, then without further investigation I would have to accept their statement. I personally believe there are many, many optometrists who have not been so examined and who would not meet the qualifications which they describe.

COMMISSIONER BALTZAN: That fully answers my question.

COMMISSIONER STRACHAN: Mr. Chairman, without any preamble, may I ask this body of gentlemen what the policy of the Canadian Medical Association is towards the fluoridation of communal water supply?

DR. WODEHOUSE: We believe, sir, this valuable procedure should be encouraged.

COMMISSIONER McCUTCHEON: You believe it should be done?

DR. WODEHOUSE: Should be encouraged. Fluoridation of water supply should be encouraged.

COMMISSIONER McCUTCHEON: How do you encourage something? Don't you want to put something in the water?

DR. WODEHOUSE: Mr. Chairman, we, in



Wodehouse

10180

1
2
3
4 this fair city, have been dealing with this thing for
5 two years. Now we are going to have a plebiscite.
6 How on earth people are going to vote on a plebiscite
7 with all the confusion, all the authoritative and
8 unauthoritative statements that have been made, I
9 wouldn't know.

10 We think that we have examined all the
11 authoritative statements. We think the claim of the
12 Commission held in Ontario, the Morden Commission,
13 chaired by a member of our judiciary, composed of repu-
14 table people to look into all aspects, and they came up
15 with what, to me, is irrefutable evidence that show its
16 benefits and show its safety and, in spite of that,
17 Mr. Chairman, we are now going to have a plebiscite over
18 something that, in regard to flavour buds, taste buds,
19 could have no possible effect on the population but we
20 know that if we put fluoride in their water it would
21 cut down the incidence of dental caries.

22 COMMISSIONER VAN WART: Turning to
23 Appendix E on your table, that is on the Federal
24 Health Grants, and just an explanation on terms. This
25 is giving an amount of money to each of the provinces
26 and percentage approved. Approved by whom?

27 DR. WODEHOUSE: Mr. Chairman, I think
28 I will turn this area over to Dr. Kelly, if I may. He
29 is more expert on it than I am.

30 DR. KELLY: Mr. Chairman, the award of
National Health Grants is by Order in Council. The
federal authority provides a global sum of money and
apportioned it among the provinces mainly on a population



Kelly

10181

basis.

Some instances it is matching and in some instances no matching requirements obtain. Then to obtain the money which has been made available, the province must originate projects and submit those projects for approval by the Department of National Health and Welfare. It's almost true to say that approved projects have their money spent. There is a slight difference because of the time lag between the end of a fiscal year and the other and so, for the purpose of this table, we took the approved projects to mean money actually allocated to the provinces of those particular grants.

COMMISSIONER VAN WART: The province must make application for the grant, primarily?

DR. KELLY: Yes. I believe in 1948 a blanket application was made for the National Health Grants which were then available to the provinces.

All the provinces indicated their desire to accept them. From that point on they are more selective in the projects which they originate. Each of those projects must be submitted, must be approved by the federal authority before any money is paid out to the provinces.

COMMISSIONER McCUTCHEON: In the case of matching grants, of course, the province must ---

DR. KELLY: Put up the same amount.

COMMISSIONER McCUTCHEON: Put up the same amount.



10182

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

/ss

The percentage approved varies all the way from one per cent to one hundred per cent. That would mean the Provinces are not making applications or would the answer be the Federal Government has disapproved?

DR. KELLY: That is right, that is an example of matching grants. I think the variable percentage used is a reflection of the activity of hospital building in the Provinces concerned. In some instances it has been slow, because they haven't got the money to match this or provide the other 80% which is required to build a hospital there. The Provinces that haven't been active in hospital building are affected in the percentage of approved grants.

COMMISSIONER VAN WART: In the final analysis all grants, Federal grants before they become operative must have the approval of the Federal Government.

DR. KELLY: That is right, it is on a project approval basis in each instance.

COMMISSIONER VAN WART: Thank you.

DR. WODEHOUSE: Mr. Chairman, could I draw your attention in that connection to emphasize the point brought forward in recommendation 17 that hospital construction grants be increased to provide a higher proportion of the cost of new approved hospital beds. The hospital, on the hospital construction grant furnished in 1948, the Federal Government paid \$1,000.00 per hospital bed for approved construction. This has been raised recently to \$2,000.00. However, in the meantime the cost of construction in hospital beds has gone up astronomically. It is now around 16, 17, 18. We feel



The percentage of the total cost of the project is

the way from one per cent to one hundred per cent.

It is the Province's responsibility to provide the money.

Would the money be the Federal Government has been

Mr. KELLY: That is right, that is

an example of matching money. I think the variable

percentage used is a reflection of the activity of hospital

building in the Province concerned. In some instances

it has been slow, because they haven't got the money to

match this or provide the other 80 per cent which is needed to

build a hospital. The Province has provided the

active in hospital building, are affected in the percentage

of approved grants.

Mr. KELLY: That is right, in the final

analysis all grants, Federal grants before they become

operative must have the approval of the Federal Government

Mr. KELLY: That is right, it is on a

project approval basis in all instances.

draw your attention in that connection to the fact that

which brought forward in recommendation 17 that hospital

construction grants be increased to provide a higher

proportion of the cost of new approved hospital beds.

the hospital, on the hospital construction grant basis

in 1967, the Federal Government paid 50 per cent

hospital had 50 approved construction. This has been

about 100,000 to 120,000. However, in the meantime

the cost of construction in hospital beds has gone up

the cost of construction in hospital beds has gone up



Wodehouse 10183

the \$2,000.00 of Federal contribution should be higher, but how much higher we don't know -- maybe \$4,000.00, maybe 50%. It should be higher than \$2,000.00 if the purpose of the grant is to fulfill its role.

THE CHAIRMAN: The Ontario Hospital Association has suggested it should be one-third; one-third to the local community, one-third to the Province and one-third at the Federal level.

DR. WODEHOUSE: It seems reasonable to us, sir. This is getting into figures. We cannot say any more than we think it should be higher than it is at present. The same thing with the others, they should be increased within all areas, particularly mental health and medical rehabilitation grants. We feel, however, in these two areas and in the general professional training grants it should be increased to encourage people to enter these fields.

THE CHAIRMAN: Now, gentlemen, we are very grateful to you. While you are still here, if there are any further observations or comments any one of you gentlemen wish to make we would be pleased to hear it.

DR. WODEHOUSE: I have one comment before our official thanks are given to you. I have been most impressed with your Commission. I appreciate the treatment we have received in our hearing today, and in each of our associational, divisional hearings across the country. I think you are doing a good job, and more power to you.

THE CHAIRMAN: Dr. Halpenny and your associates, I want to say when we received your brief, we



Wodehouse 10184

were impressed with the amount of work and thought that had gone into making the presentation. Your views have been set forward quite clearly. I think we understand where you stand. We will have the representations that have been made well in mind when we come to consider our final report.

DR. HALPENNY: May I, on behalf of my colleagues and the Executive Committee of the C.M.A., thank you, and through you the Members of the Commission for listening to us today. You will note that the answering has been done by the three members of the sub-committee while the two represented on each end sat silent. This was because the three members of the special committee have been literally sleeping and eating with this brief for nearly a year. It was felt they were the most competent ones to answer the searching questions. We hope we have answered those questions, sir, and we are very grateful to you and to have this opportunity of presenting the brief and the conclusions of the Canadian Medical Association. Thank you.

THE SECRETARY: Before Dr. Kelly leaves he left with me to be filed four briefs which will be filed as 278A, Brief of the Canadian Thoracic Society; 278B, Brief of the Canadian Orthopaedic Association; Exhibit 278C, the Brief of the Canadian Otolaryngological Society and Exhibit 278D, Brief of the Canadian Life Insurance Medical Officers' Association.

---EXHIBIT NO. 278A: Brief of the Canadian Thoracic Society.



10185

---EXHIBIT NO. 278B: Brief of the Canadian Orthopaedic Association.

---EXHIBIT NO. 278C: Brief of the Canadian Otolaryngological Society.

---EXHIBIT NO. 278D: Brief of the Canadian Life Insurance Medical Officers' Association.

THE CHAIRMAN: Gentlemen, before you leave, in relation to these four documents, we haven't had an opportunity to read them, but I put a general question. I am sure Dr. Kelly knows what is in there.

DR. KELLY: Yes, sir, these are the submissions of four of our professional affiliates in Canada. They filed them with us rather than presenting them personally because they are largely informative in their areas of interest. The information in there has been made known to the members of the Executive Subcommittee, and what they felt was pertinent to be added to this brief has been incorporated. It is largely informative. I think you will find very few recommendations among those. We do feel that the particular areas of interest of those groups concerned should be drawn to your attention.

THE CHAIRMAN: You see, the last one is the Canadian Life Insurance Medical Officers and they say, Paragraph 5, discussing plans: "There should be a prescribed maximum premium for an essential form of coverage." Now, that is new, at least insofar as your own presentation here today is concerned. The question I



Kelly 10186

was going to put to you, having been aware of what is in there, are there any recommendations that are at variance or a departure from the recommendations made by the parent body here today?

DR. KELLY: No, sir. They are framed in a different fashion than we phrased our own. I think the point you have mentioned is covered by our suggestion that to provide medical service insurance to the people who find it difficult now to finance that, that an approving agency of the carriers worthy of receiving public funds for that purpose be established, and it would be one of the privileges, I imagine, of such an approving agency that they would establish a maximum premium. We regard that feature as part of the function of the approving agency.

THE CHAIRMAN: You see, in five in the recommendations it is the "plans should be on a voluntary basis permitting any person, regardless of age, state of health or occupation, the opportunity of prepaying the cost of future health services at a reasonable premium rate". Up to there that is what you said today, then this document goes on to say: "There should be a prescribed maximum premium for an essential form of coverage". I am wondering if the use of the word "essential" is synonymous with minimum. Is that what they would have in mind?

DR. WODEHOUSE: The Canadian Life Insurance Medical Officers are a very valued adjunct of our Association. They fall into two camps, one our camp, C.M.A. and the other the Insurance Company camp, who are



July 1941

was going to put it out, but it was not

in there, and there are some recommendations that are

in a separate form from the recommendations made by the

parent body here.

Mr. [Name] (to the [Name] and [Name])

in a different fashion than we passed on our own. I think

the point you have mentioned is covered in our report on

that to provide a more effective framework to the people

and find it difficult to do so. I think that an

a growing agency of the country would be receiving public

in the way that purpose is established, and it would be

one of the principles, I think, of such an agency.

Agency that they would establish a maximum number of

agency that would be part of the function of the

growing agency.

Mr. [Name] (to the [Name] and [Name])

the recommendation that is the "plans" would be on a

voluntary basis, permitting any person, regardless of

age, state of health or occupation, the opportunity of

preparing the cost of future health services as a person

in the "plans" is to those that is when you said

that, then this recommendation is to say: "I have shown

as a proposed maximum number for an essential one of

however, it is not one of the use of the word

"essential" is not one of the use of the word

then we have in mind.

Mr. [Name] (to the [Name] and [Name])

insurance medical, it is a very varied picture of a

association. They will have two camps, one on one

M.A. and the other the Insurance Company, who are



Wodehouse 10187

their employers, for whom they work. They are the gentlemen that in large part were responsible for improvement in the insurance coverage offered by commercial insurers. I believe you have a group coming to you from the Canadian Health Insurance Association.

THE CHAIRMAN: Tomorrow morning.

DR. WODEHOUSE: It will be put forward to you their views of pooling and the coverage of difficult risks. We are aware of their views. They are not our views. We are not putting them forward, but I think it is fair to say, sir, we are aware of their views in general, but not in detail, and we think it is a mechanism which could be applied. I think you will find, sir, that this paragraph you are reading really refers to that thinking rather than to our own thinking and recommendations.

THE CHAIRMAN: Thank you very much.

SUMMARY AND CONCLUSIONS OF SUBMISSION OF THE CANADIAN
THORACIC SOCIETY, Exhibit 278A

1. The Canadian Tuberculosis Association has for 60 years been concerned with the early diagnosis of tuberculosis, treatment and prevention, public and professional education, research and rehabilitation.

2. Its medical section was in 1957 widened in scope to include the study of the whole field of thoracic disease and was renamed the Canadian Thoracic Society.

3. The Canadian Thoracic Society acts as advisor on medical policy to the Canadian Tuberculosis



10188

Association and provides the means whereby doctors in Canada have joined together to study tuberculosis, thoracic and other diseases.

4. The full objectives of the Society are outlined on Page 4, Paragraph 24, of this submission.

5. Even though the incidence of new tuberculosis cases is lessened and control of the disease is in sight, pulmonary tuberculosis is still a disease of major significance.

Training and recruitment

6. For many years to come physicians with special training in tuberculosis as well as the broad field of chest diseases will be needed if control is eventually to be attained.

7. There has in recent years been an appreciable loss of physicians and surgeons experienced in the field of tuberculosis, and the necessity for recruitment and education in this field is stressed.

8. The Canadian Thoracic Society and its provincial branches are developing an active program of continuing medical education.

9. The importance of undergraduate and postgraduate training of future chest physicians in university medical centres and other large chest centres is also stressed if a future shortage is to be avoided.

10. The attractiveness of training in tuberculosis sanatoria has waned considerably. In the future, more and more treatment of active tuberculosis will be centred in special units with adequate isolation in general hospitals or in chest centres close to general



association and prove as the years when the doctor is
 unable have to get together to study tuberculosis,
 thoracic and other diseases.

4. The full objectives of the Society are
 outlined on Page 4, Paragraph 1, of this constitution.
 5. Even though the incidence of new

tuberculosis cases is decreasing, and control of the disease
 is in sight, pulmonary tuberculosis is still a disease
 of major significance.

Training and Research

6. For many years to come physicians with
 special training in tuberculosis as well as the broad
 field of chest diseases will be needed in control in
 order to be effective.

7. There has in recent years been an
 appreciable loss of physicians and surgeons experienced
 in the field of tuberculosis, and the necessity for
 recruitment and education in this field is stressed.

8. The Canadian Thoracic Society and its
 provincial branches are developing an active program of
 continuing medical education.

9. The development of university and
 postgraduate training of future chest physicians in
 university medical centres and other large chest centres
 is also stressed as a future objective to be achieved.

10. The attractiveness of training in
 tuberculosis research has been considerably lessened in the
 past, more and more research of active tuberculosis
 will be carried in special units with adequate isolation
 in order of research on in these centres close to general



1
2
3
4 hospitals. In this way internships could be provided
5 in the chest disease service, including tuberculosis
6 training. There will still, however, be a need for some
7 sanatorium beds as outlined below.

8 Future Hospital Requirements

9 11. Active treatment requirements for
10 tuberculosis will slowly diminish over the years. However,
11 the importance of the sanatorium for basic patient training
12 and education, investigation and establishment of treat-
13 ment routines must be recognized. And certainly tuber-
14 culosis hospitals should not be closed till replaced by
15 adequate chest centres.

16 Relation of Tuberculosis and Chest Diseases to the General 17 Medical Program

18 12. With shortened institutional treatment
19 of patients with tuberculosis, greater responsibility will
20 fall on the family physician and the internist for the
21 follow-up treatment. Tuberculosis will become increasingly
22 significant therefore as part of the general medical
23 program.

24 13. With a shorter period of treatment the
25 need for closer follow-up becomes more important by the
26 establishment of chest centres, adequately staffed and
27 well equipped, and near the patient's home, these centres
28 to have a close liaison with and some direction from the
29 Central Tuberculosis Registry.

30 14. It is absolutely essential that this
central tuberculosis registry be kept by the public health
authorities in each province, as a part of their respon-
sibility for the overall supervision and control of
tuberculosis.



10190

Research

15. Much basic research needs to be done in the whole field of respiratory disease. Stimulation by universities is necessary.

16. The importance of research in large non-teaching centres and also in smaller centres should be recognized.

SUMMARY AND RECOMMENDATIONS OF THE CANADIAN ORTHOPAEDIC

ASSOCIATION, Exhibit 278B

The Canadian Orthopaedic Association offers three main recommendations:

- i) that this organization, through its association with the Royal College of Physicians and Surgeons of Canada, continue as the national advisory body in orthopaedic problems with particular reference to a) undergraduate and post-graduate orthopaedic training, b) the health care of all persons with any orthopaedic disorder, especially those orthopaedic disorders resulting from trauma and degenerative processes, and c) orthopaedic research,
- ii) the recognition of the rapidly increasing number of aged persons with musculo-skeletal disease requiring orthopaedic care,
- iii) the establishment of a gradually



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

10191

1
2
3 increasing number of organized
4 orthopaedic units for the preven-
5 tion and treatment of the rapidly
6 increasing number of patients
7 disabled by trauma and degenerative
8 disorders.
9
10
11
12
13 -
14
15
16
17
18 -
19
20
21
22
23 -
24
25
26
27
28
29 -
30



10192

GENERAL REMARKS AND RECAPITULATION OF THE SUBMISSION OF
THE CANADIAN OTOLARYNGOLOGICAL SOCIETY

Exhibit 278C

Some politicians of the day would have us believe that the alleviation of the medical miseries of mankind are the sole property of a particular political philosophy. Can anyone, truthfully, deny that the medical profession have from time immemorial been associated with misery and disease? Has any group of our citizens done more to alleviate pain and suffering? We, of the medical profession, are good Canadian citizens and as such, we, likewise, are vitally interested in the health and welfare of Canadians.

We do not believe that the health and welfare of Canadian citizens can be materially advanced by making the medical profession a series of numbers of the scheme of civil servants.

We do believe that the health and welfare of our citizens may be enhanced in the following manner.

1) The liberation of some segments of our community from slum areas, the establishment of proper housing, and an increase in the nutritional standards of these unfortunates should be given top priority in a general scheme for better health of our citizens.

That a large proportion of our citizens can and do afford pre-paid medical insurance is well known. It is equally certain that a large part of those not now covered by pre-paid medical insurance schemes could



afford it if they were willing to make the sacrifice. Many accept as a calculated risk the possibility of a medical calamity. This surely is their privilege.

There remains a segment of the population who perhaps through no fault of their own, but misadventure, find themselves incapable of supplying proper shelter, heating, clothing, education, nutrition and medical care to themselves or those dependent on them. It is to this segment of the population that government at all levels should direct some resources; - this in the name of humanity.

2) We believe it is an anomalous situation that in some areas of Canada, more than fifty per cent of the registrations are made by medical men from foreign countries, whilst, for many years more than twenty-five per cent of Canadian graduates have emigrated to another country, principally, the United States, in order to pursue a medical career.

3) We believe that the field of medicine must be made more fertile if we are to obtain good students for our universities and to retain our own graduates.

4) We believe that good medical students should be compensated during the period of undergraduate training and the cost of post graduate training be considered a proper deductible expense.

5) We believe in the principle of depreciation of buildings and machinery on the basis of obsolescence. We also believe that obsolescence of the human body should be given consideration. Some means must be found to allow the medical profession, and indeed other professions



10194

and persons individually employed the right to defer a greater proportion of savings from the higher income years for the purposes of security in later years. This may be accomplished by allowing a greater proportion of income for the Retirement fund or by reducing the rate of taxation with increasing years; the latter method would be based on the premise of obsolescence.

6) We believe the medical profession is no longer the land of enchantment, full of magic, delight and fascination for the collegiate student. If Medicine is to survive and the good derived from its knowledge made available to present and future generations of Canadians then medicine must be made more attractive to potential students.

This can be accomplished by extending and improving the facilities for undergraduate training; by establishing more centers for post graduate training; by encouraging more basic and clinical research centers; in a word, provide some of the incentive and tools to get on with the job of improving the medical lot of man.

The government and politicians should be making endeavours to encourage medical practice, research and the retention of our graduates within our own country rather than deprecating our endeavours. The dispersal of the ominous overhanging clouds of bondage in a socialistic scheme would go far in revitalizing medicine and encouraging potential students.

7) We believe there is a pie in the sky, attainable with education, hard work, patience, and fortitude. The size of the pie must be consistent



1
2
3
4 with our ability to pay. It is manifestly foolhardy
5 to divert such proportion of our gross national income
6 for the production of a welfare state that all other
7 facets of the economy, commerce and industry etc., are
8 tethered and incapable of making progress or adjustment
9 in a changing competitive world.

10 Some countries, one, in particular,
11 which we hold in high esteem, have become so imbued with
12 governmental paternalism, from the cradle to the grave,
13 that the country has been brought to the verge of
14 bankruptcy as the people are surfeited by solicitous
15 subscribers to socialism.

16 It is hoped that Canada will learn
17 from history and that haste into welfare innovations will
18 be made slowly and steadily on firm foundations; leaving
19 industry, commerce and corporations sufficient latitude
20 such that life in Canada will not be stagnated but rather
21 move onward and forward in an orderly progression.

22 The Canadian Otolaryngological Society
23 extends our best wishes to the Royal Commission on Health
24 Services as they attempt to make Canada a better place
25 in which to live.

26 It has not been possible to communicate
27 with all members of the Canadian Otolaryngological
28 Society, but it is hoped that some at least of the
29 thoughts expressed in this brief will meet with their
30 approval.

31 The undersigned, therefore assume
32 responsibility for the brief which is submitted for your
33 consideration.

Walter Alexander, Thomas E. Briant



SUBMISSION OF
CANADIAN LIFE INSURANCE MEDICAL OFFICERS
ASSOCIATION - EXHIBIT 278D

1. The Canadian Life Insurance Medical Officers Association is an affiliate of the Canadian Medical Association and is composed of 86 doctors of medicine who are advisors to Insurance Companies that supply a significant percentage of the Health Insurance coverage now in force. Therefore this body, through special training and experience, believes it is competent to express an opinion and make recommendations with regard to Health Services.

2. As members of the Medical Profession this organization is naturally greatly concerned with the adequate health care of the Canadian people.

3. We believe that a strong positive approach should be taken. A definite Plan that would permit the prepayment of Medical Services should be presented as an alternative to overall (or complete) Government control of Health Services.

4. The Canadian Life Insurance Medical Officers Association is in agreement with the five beliefs and with the basic tenets of the fourteen principles outlined in the statement on Medical Services Insurance approved by the General Council of the Canadian Medical Association at their 93rd Annual Meeting of June 1960. The Canadian Life Insurance Medical Officers Association believe in addition, that the individual should have the right to choose the method by which he will pay for his medical care and the right



1
2
3
4 to be insured by the insurer of his choice in the event
5 that he wishes to prepay his medical care on either a
6 full service or indemnity basis.

7 5. In our opinion any Plan or Plans
8 should be on a voluntary basis permitting any person,
9 regardless of age, state of health or occupation, the
10 opportunity of prepaying the cost of future Health
11 Services at a reasonable premium rate. There should be
12 a prescribed maximum premium for an essential form of
13 coverage.

14 6. The details of Essential Medical
15 Services should be defined through consultation with all
16 interested parties. In our opinion, however, Essential
17 Medical Services should cover all medical fees whether
18 in or out of hospital in the case of the Indigent and
19 the Marginal Income group, as later defined, but should
20 not exceed the fees as set out by the Provincial
21 Schedule of Fees of the province in which the service
22 was rendered. This essential coverage should be available
23 to all individuals through all carriers at a reasonable
24 rate not to exceed a fixed maximum premium rate.

25 7. In that group of the population who
26 can afford to pay for all their health care, there
27 should be available in addition to the essential
28 coverage, as defined above, less broad (such as in-
29 hospital coverage only) or broader coverage with a
30 lesser or increased premium dependent on the coverage
they choose to purchase.

8. Competition is the fundamental basis
of free enterprise. We believe that in order to achieve



1
2
3
4 the greatest benefits at the lowest cost, coverage
5 should be available through all licensed carriers.

6 9. The Canadian Life Insurance Medical
7 Officers Association believe that the problem of the
8 Marginal Income group, including some portion of the
9 unemployables, and probably the unemployed at some
10 point of time, must of necessity require a government
11 subsidy though at a much lesser overall cost than a
12 completely comprehensive government plan.

13 Indications are that many of the
14 medical profession are willing to continue the
15 principle of accepting reduced fees for certain sections
16 of the population where such need may be indicated.
17 If the medical profession is willing to continue its
18 traditional role of subsidizing the care of this group
19 to some degree, it does not seem unreasonable that the
20 government should also share the cost of the care of
21 the Marginal Income group, as defined above.
22
23
24
25
26
27
28
29
30



the greatest benefit to the largest group, covering
about as available through all local and national
... the ...
... Association ... the ... of the
... Income ... some portion of the
... and possibly the ... of the
point of time, must be necessarily ...
... at a ... of ... that a

indications are ... of the
... medical profession ... the
principle of ...
of the population where ...
... the medical profession is ...
... role of ... of this group
to some degree, ... the fact that
... should also share the ... of the ...
... income ...



10199

THE SECRETARY: Mr. Chairman, I would like to call forward the College of General Practice of Canada, which will be known as Exhibit 279. Dr. Johnston will present his group.

S U B M I S S I O N O F
THE COLLEGE OF GENERAL PRACTICE OF CANADA

---EXHIBIT NO. 279: Submission of the College of General Practice of Canada.

APPEARANCES:

DR. W.V. JOHNSTON
DR. I.W. BEAN
DR. J.T. McCULLOUGH
DR. D.E. HUNT

THE CHAIRMAN: Dr. Johnston.

DR. JOHNSTON: Mr. Chairman, Members of the Royal Commission on Health Services, I would like to introduce to you my colleagues. On my immediate right our President, Dr. I. Bean; next to him is Dr. McCullough who is President-elect, and at the far end Dr. D. Hunt, who is Chairman of our Board of Representatives, which is the governing body of the College.

THE CHAIRMAN: May I invite you to sit down if you will.

DR. JOHNSTON: Do you wish me to read?

THE CHAIRMAN: It is in your hands, handle it whichever way you want.

DR. JOHNSTON: Thank you. I will read



Johnston

the summary and the recommendations which are not very long.

S U M M A R Y

1. The College of General Practice of Canada was established by the Canadian Medical Association in 1954 to help general physicians keep their professional skills up to date. Good medical care for the people of Canada is the primary aim.

2. The College of General Practice is concerned primarily with upgrading the standard of medical care as provided by the general practitioner.

3. It functions as an educational and standard setting body to integrate the general practitioner into the whole field of academic medicine in Canada.

4. The College presents this brief to the Royal Commission on Health Services as a progress report. In this it emphasizes what is being done through the collective effort of the general physicians themselves, and with the assistance of others.

5. This work is in its beginning and the College hopes for further progress towards an expanding and more efficient role for the Canadian family doctor.



G/hm

Johnston

10201

1. The College of General Practice welcomes responsible efforts to increase the number of family physicians in Canada today.

2. The College feels that the provision of better conditions for practice in understaffed areas would lead to a better distribution of doctors. These conditions would have to include laboratory, x-ray and hospital facilities and provision of consultant services. It is difficult and discouraging to provide a good family medical service without these at hand.

3. In the field of undergraduate medical education:

(a) That a thorough review and probably revision of the whole medical curriculum is a fundamental necessity, keeping in mind that the general physician has one of the most important roles in medicine.

(b) That more emphasis be placed in medical schools on general practice as a major branch of medical practice (and not merely the absence of specialty), and that an essential feature of this orientation be instruction in family medical care by experienced family doctors.

(c) That there is a need for representation by general practitioners on medical school curriculum committees -

- i. to create awareness, interest and respect for general practice;
- ii. to provide the necessary factual, theoretical and technical knowledge for

1911

The College of General Practitioners

1.

whereas a person with a certificate in medicine is a member of

family physician in Canada.

2.

The college feels that the members

of better conditions for practice in unincorporated

areas would lead to a better distribution of doctors.

These conditions would have no effect on laboratory, X-ray

and hospital facilities and other services of a community.

It is difficult and expensive to provide

a good family doctor service without some of these

3.

in the field of general practice.

edition:

(1) That a person who is a member of the college

of the whole of the province is a member

of the college and is a member of the college

and is a member of the college and is a member of the college

and is a member of the college.

(2) That those registered by the college in medicine

on general practice are a member of the college

medical practice (and not necessarily the college

of general practice), and that all members of the college

of this college are members of the college

and are a member of the college and are a member of the college

(3) That there is a need for recognition by

general practitioners on medical practice

and is a member of the college.

4. To create awareness, interest and

to provide the necessary

and is a member of the college.



Johnston

10202

preparing the student to proceed to
general practice or any other specialty.

4. That more residencies in general
practice be available and that financial assistance be
provided to hospitals for the reasonable payment of
residents occupying these positions.

5. The College hopes for the fullest
support of its appeal to the Minister of Finance for
income tax deduction of expenses of family doctors'
attendance at approved refresher courses, necessary for
the maintenance of their standards.

6. The College hopes for an increase
in the number of scholarships and bursaries available to
its members for participation in intensive refresher
courses.

7. The College recommends that facilities
for continuing education for practicing general physicians
be made increasingly available.

8. The College hopes for a steady
expansion of emphasis on clinical research by general
physicians of projects where they are well qualified
to provide information.

9. That every effort be made to get
clearer recognition -

(a) of the privilege of the general physician
to treat his patients in any hospital in
his community where he might reasonably be
expected to send his patients according to
his competence, and in so doing, recognizing
that responsibilities always go with privileges;



Johnston

10203

(b) that through hospital appointments the general practitioner can and should play an important role in both graduate and undergraduate medical education.

10. The College assures that Canada's family doctors will continue to accept an ever increasing responsibility for leadership and service in rapidly expanding areas such as the fields of mental illness, rehabilitation, preventive medicine and home care plans. These are some of the new frontiers of service which will receive appropriate attention.

That sir is a summary of our recommendations.

THE CHAIRMAN: Thank you Dr. Johnston. Now, would you or one of your colleagues, dealing with your recommendation number 9. Is it implicit in this recommendation that there is dissatisfaction by the general practitioners with regard to access to hospitals?

DR. JOHNSTON: There is some dissatisfaction. There is dissatisfaction in some areas.

THE CHAIRMAN: Would you expand that, Dr. Johnston?

DR. JOHNSTON: It is patchy, and I don't know. It would be rather, it would not be easy just to give a complete picture.

THE CHAIRMAN: I am talking of the areas, I am not talking perhaps territorially, areas of practice more than geographical areas?

DR. JOHNSTON: There are two facets to general physicians practising in hospitals. One is



that general hospital appointments are
general practitioners can and should play an
important role in both graduate and under-

10. The College agrees that general

family doctors will continue to exert an ever increasing
responsibility for leadership and service in rapidly
expanding areas such as the fields of mental illness,
rehabilitation, preventive medicine and home care clinics.
These are some of the new frontiers of service which
will receive appropriate attention.

That this is a variety of

15. THE CHAIRMAN: Thank you Dr. Johnston.

Now, would you or one of your colleagues, dealing with
your recommendation number 8, in its entirety in this
recommendation that there is dissatisfaction by the

19. general practitioners with regard to access to hospitals?
DR. JOHNSON: There is some dissatisfaction.

20. There is dissatisfaction in some areas.

21. THE CHAIRMAN: Would you expand that,

22. Dr. Johnston?

23. DR. JOHNSON: It is patchy, and I
don't know. It would be rather, it would not be even
just to give a complete picture.

25. THE CHAIRMAN: In talking of the
areas, I am not talking perhaps particularly, areas
of practice more than geographical areas.

26. DR. JOHNSON: There are two factors
to general practitioners concerned in hospitals. One is



Johnston

10204

1
2
3
4 the ability to treat their patients in hospital, and
5 by this I mean men who are competent to do so. That
6 is one facet. Now, the other facet is the privilege
7 of the general practitioner to be on the active staff
8 of the hospital, and to take a part in the medical staff
work of that hospital.

9 Those are rather two different parts
10 of this question. The one that we are particularly
11 interested in is that the general physicians have the
12 privilege of being on the staff, on the active staff,
of all large general hospitals.

13 THE CHAIRMAN: Would you exclude the
14 teaching hospitals?

15 DR. JOHNSTON: No, we don't exclude
16 them, and at the moment there are ten or twelve of the
17 teaching hospitals developing such departments of
18 general practice, and integrating the general physician
19 into the teaching hospital through such departments. We
20 don't exclude. We do admit that it may be a little
21 more difficult. I would like to ask one or two of my
colleagues.

22 DR. BEAN: To make a generalization,
23 Mr. Chief Justice Hall, that all general practitioners
24 should be allowed on the staff of our teaching hospitals
25 anymore than all surgeons within the particular area,
26 or all internists are necessarily on the staff of
teaching hospitals. I believe it has been the prerogative
27 of teaching hospitals to attempt to select for their
28 teachers outstanding men in their field throughout,
29 be it a surgeon, an internist, an orthopaedist, or what
30



the ability to treat their patients in hospital, and
 by this I mean men who are competent to do so. That
 is one facet. Now, the other facet is the privilege
 of the general practitioner to be on the active staff
 of the hospital, and to take a part in the medical staff
 work of that hospital.

These are rather two different parts
 of one question. The one that we are particularly
 interested in is that the general physicians have the
 privilege of being on the staff, on the active staff,
 of all large general hospitals.

THE CHAIRMAN: Would you exclude the
 teaching hospitals?

DR. JOHNSON: No, we don't exclude
 them, and at the moment there are ten or twelve of the
 teaching hospitals developing such departments of
 general practice, and interesting the general physician
 into the teaching hospital through such departments. We
 don't exclude. We do admit that it may be a little
 more difficult. I would like to ask one or two of my

DR. BEAN: To make a generalization,
 should be allowed on the staff of our teaching hospitals
 anyone other than all surgeons within the traditional ones,
 on all internists are necessarily on the staff of
 teaching hospitals. I believe it has been the practice
 of teaching hospitals to attempt to select for their
 teachers outstanding men in their field throughout,
 be it a surgeon, an internist, an orthopedist, or what



Johnston

10205

1
2
3
4 have you, and the plea that we have here primarily is
5 tied in with the teaching of the medical student, that
6 we would have a good core of general practitioners who
7 would be on the staff of the teaching hospital for the
8 purposes of teaching the students.

9 DR. McCULLOUGH: I think, Mr. Chairman,
10 that we have two rather individual problems here. We
11 have the teaching hospitals and the non-teaching hospitals,
12 and as Dr. Bean has outlined, there is a rather special
13 problem in the teaching hospitals. With regard to the
14 non-teaching large general hospital, it is our feeling,
15 and our contention that every general practitioner should
16 have access to some good hospital in his neighbourhood
17 for the benefit of his patients, and also ---

18 THE CHAIRMAN: Is it a fact that many
19 have not such access?

20 DR. McCULLOUGH: In the larger centres,
21 that is true. This I say is for the benefit of not only
22 his patients, but of course for himself, and that comes
23 back to the patient again. The man who practises in
24 a good hospital practises better medicine than the man
25 who is not affiliated.

26 THE CHAIRMAN: We had in another regard
27 that the general practitioner was described as a sign
28 post, to direct the patient to the hospital.

29 DR. JOHNSTON: We don't like that
30 definition sir.

THE CHAIRMAN: Whether, Dr. Johnston,
the definition may not be an appropriate one in that
sense, but the idea behind it, is that concept prevalent



have you, and the idea that we have here primarily is tied in with the teaching of the medical student, that we would have a good case of general practitioners who would be on the staff of the teaching hospital for the purposes of teaching the students.

MR. McCULLOUGH: I think, Mr. Chairman, that we have two rather fundamental problems here. We have the teaching hospitals and the non-teaching hospitals and as Mr. Bean has outlined, there is a rather special problem in the teaching hospitals. With regard to the non-teaching large general hospital, it is our feeling, and our contention that every general practitioner should have access to some good hospital in his neighbourhood for the benefit of his patients, and also ---

THE CHAIRMAN: Is it a fact that many have not such access?

MR. McCULLOUGH: In the former country, that is true. This I say is for the benefit of not only his patients, but of course for himself, and that comes back to the patient again. The man who practices in a good hospital practices better medicine than the man who is not affiliated.

THE CHAIRMAN: We had in another regard that the general practitioner is described as a sign post, to direct the patient to the hospital.

MR. McCULLOUGH: We don't like that

the distinction may not be an appropriate one in that sense, but the idea behind it, is that concept prevalent



Johnston

10206

1
2
3 or developing in Canadian medicine?

4 DR. JOHNSTON: No, we are only eight
5 years old, but the concept is very rapidly developing
6 that general practice is a specialty in itself, and
7 therefore it must be much more than just simply directing
8 traffic, and it has got inherently a great deal of
9 services of its own, that no one else can deal with
10 as well as he can.

11 THE CHAIRMAN: And that is without
12 reference to a hospital at all?

13 DR. JOHNSTON: That is right.

14 THE CHAIRMAN: Well, if that is so,
15 why the hospital?

16 DR. JOHNSTON: It makes him a better
17 doctor. For instance, one of our largest hospitals,
18 with 1,600 beds, in which no general physician could
19 be on the active staff, no matter how good he was, and
20 if he was there 20 years, up to two years ago, and now
21 they have 24 on the active staff. One of them told me
22 that one of the most stimulating things is happening
23 to him, being in the hospital treating his patients and
24 working with the active staff. It simply makes him a
25 better doctor.

26 THE CHAIRMAN: Well, you appreciate
27 that the idea of any system in which the general
28 practitioner has not access to the hospital as a
29 member of its staff is bringing us very close to the
30 type of medical practice the general practitioner
practises in England, where the general practitioner
just does not go to the hospital. Do you see that



or developing in Canadian medicine?

DR. JOHNSTON: No, we are only eight

years old, but the concept is very rapidly developing.

That general practice is a specialty in itself, and

therefore it must be much more than just simply directing

traffic, and it has got inherently a great deal of

services of its own, that no one else can deal with

as well as he can.

THE CHAIRMAN: And that is without

reference to a hospital at all?

DR. JOHNSTON: That is right.

THE CHAIRMAN: Well, if that is so,

why the hospital?

DR. JOHNSTON: It makes him a better

doctor. For instance, one of our largest hospitals,

with 1,200 beds, in which no general physician could

be on the active staff, no matter how good he was, and

if he was there 20 years, up to two years ago, and now

they have 24 on the active staff. One of them told us

that one of the most stimulating things is happening

to him, being in the hospital treating his patients and

working with the active staff. It simply makes him a

better doctor.

THE CHAIRMAN: Well, you agree

that the idea of any system in which the general

practitioner has not access to the hospital as a

series of the staff is bringing us very close to the

type of medical practice the general practitioner

was close in England, where the general practitioners

just does not go to the hospital. Do you see that?



Johnston

10207

1
2
3
4 developing here? Is that the -- are we departing from
5 the historical trend which was started in America and
6 going back to the historical situation in England?

7 DR. JOHNSTON: I don't think so. I
8 hope the trend is reversed.

9 THE CHAIRMAN: Since 1954?

10 DR. JOHNSTON: Since 1954. There are
11 now a large number of hospitals I think have developed
12 general practice departments, and are making an effort
13 to integrate the general practitioners into the staff.

14 THE CHAIRMAN: Is the College of
15 General Practice satisfied with the curriculum of
16 medical colleges in terms of preparing general
17 practitioners?

18 DR. JOHNSTON: No, and yet, I will let
19 some of my colleagues speak to this too, but I think
20 we are not satisfied, and yet we don't want to be too
21 critical. In the medical schools they are trying steadily
22 to improve the quality of training, and we think that
23 you cannot really train general physicians unless there
24 is some instruction by general physicians, that somehow,
25 in some way, some of the instruction should be given
26 by general physicians, and we are not satisfied that
27 this instruction is nearly as good as it could be.

28 THE CHAIRMAN: What do you see it? It
29 has been represented to us on other occasions that the
30 curricula is fashioned to train specialists?

DR. JOHNSTON: I doubt if it is as simple
as that. The chief defect, as we see it, is that the
instruction is done largely by specialists, and that



developing here? Is that the -- the departing point
the historical trend which was started in America and
going back to the historical situation in England?
DR. JOHNSON: I don't think so. I

hope the trend is reversed.

THE CHAIRMAN: Since 1945

DR. JOHNSON: Since 1945. There are

now a large number of hospitals I think have developed
general practice departments, and are making an effort
to integrate the general practitioners into the staff.

THE CHAIRMAN: Is the College of

General Practice satisfied with the curriculum of

medical colleges in terms of preparing general

practitioners?

DR. JOHNSON: No, and yet, I will let

some of my colleagues speak to this too, but I think

we are not satisfied, and yet we don't want to be too

critical. In the medical schools they are trying steadily

to improve the quality of training, and we think that

you cannot really train general physicians unless there

is some instruction by general physicians, that is, in

in some way, some of the instruction should be given

by general physicians, and we are not satisfied that

this instruction is nearly as good as it could be.

THE CHAIRMAN: What do you see it? It

has been represented to us on other occasions that the

curriculum is fashioned to train specialists.

DR. JOHNSON: I don't think it is simple

is that. The chief defect, as we see it, is that the

instruction is done largely by specialists, and that



Johnston

10208

1
2
3
4 puts a very strong colouring on what they teach, and
5 that there is a good deal of general practice, and no
6 one else can teach it, or family practice, or cannot
7 teach it as well as the general physician.

8 THE CHAIRMAN: What recommendation
9 have you to make in the situation as you see it?

10 DR. McCULLOUGH: Mr. Chairman, I think
11 it is the feeling of the College that there should be
12 instruction in general practice, and they call it the
13 art of general practice, by people who are well versed
14 and eminent in it. There are a number of methods which
15 might be used. In some schools they use the preceptorship
16 system, where the student must spend a given length
17 of time under the tutelage of a general practitioner.
18 In some schools they are doing this on an out-patient
19 basis. Our contention is that the instruction has tended
20 to view the treatment of disease in units, and the
21 student goes to a stomach or an eye, or a kidney, and
22 not to the individual, and some of these students are
23 actually graduating with a rather impaired view of
24 practice. They have probably no more insight into the
25 treatment of the family than a man would get from a
26 documentary film of a foreign country. It is rather
27 vague in their minds, and we think this should be
28 brought home to them by instruction in general practice.

29 DR. HUNT: Mr. Chairman, this is
30 being carried out by taking our final year students and
putting them out with a family doctor for two weeks or
so, and allowing them to live in the house with the
doctor, and go with him as it were 24 hours a day. If



puts a very strong coloring on what they teach, and that there is a good deal of general practice, and no one else can teach it, or family practice, or cannot teach it as well as the general physician.

THE CHAIRMAN: What recommendation

have you to make in the situation as you see it?

Dr. McCULLOUGH: Mr. Chairman, I think

it is the feeling of the College that there should be instruction in general practice, and they call it the art of general practice, by people who are well versed and eminent in it. There are a number of methods which might be used. In some schools they use the preceptorship

system, where the student was to spend a given length

of time under the tutelage of a general practitioner.

In some schools they are doing this on an out-patient

basis. Our contention is that the instruction has tended

to view the treatment of disease in units, and the

student goes to a stomach or an eye, or a kidney, and

not to the individual, and some of these students are

actually graduating with a rather impaired view of

practice. They have probably no more insight into the

treatment of the family than a man would get from a

documentary film of a foreign country. It is rather

vague in their minds, and we think this should be

brought home to them by instruction in general practice.

Dr. HALL: Mr. Chairman, this is

being carried out by taking our final year students and

putting them out with a family doctor for two weeks or

so, and allowing them to live in the house with the

doctor, and to visit him as it were 24 hours a day. If



Johnston

10209

1
2
3
4 he is called out at night the student attends with him,
5 and attends in the office hours, and in the hospital,
6 et cetera, and we feel that this rounding out, where
7 you meet the family and the mothers and the children
8 who you have delivered over the years, and you may
9 call them by their names, is very valuable.

10 THE CHAIRMAN: Well, is that two week
11 period, do you think it sufficient?

12 DR. HUNT: No, I don't think we
13 consider it sufficient, but we feel it is a good beginning.

14 DR. JOHNSTON: This has been compulsory
15 in the University of Saskatchewan for two years.
16 Dalhousie University in Halifax is very seriously considering
17 making it mandatory.

18 THE CHAIRMAN: But it is not in the
19 other medical schools?

20 DR. JOHNSTON: Quite a number of them,
21 like Toronto, 20 or 25 medical students are out from
22 Toronto each year, to senior general practitioners. It
23 is on a voluntary basis. It is a two-week period,
24 either at the end of the third year or immediately before
25 the beginning of the fourth year, but it is on a
26 voluntary basis.

27 THE CHAIRMAN: Are the general
28 practitioners of Canada prepared to consider the much
29 greater development of the preceptory proposition, that
30 is in a sense giving employment to medical students
during the summer, during their vacation?

DR. JOHNSTON: Where these programs
are in operation there has been no difficulty at all in



10733

Journal

he is called out at night the student attends with him,
and attends in the office hours, and in the hospital,
et cetera, and we feel that this is something out, where
you rest the family and the mother and the children
who you have delivered over the years, and you may
call them by their names, as very valuable.

THE CHAIRMAN: Well, is that two week
period, do you think it sufficient?

DR. HOLT: No, I don't think so.

consider it sufficient, but we feel it is a good beginning
to the hospital: This has been compulsory

in the University of Washington for two years

Dalhousie University in Halifax is very seriously considering
making it mandatory

THE CHAIRMAN: But it is not in the
other medical schools?

DR. JOHNSON: Quite a number of them.

like Toronto, 20 or 25 medical students are out from

Toronto each year, to some or several practitioners, in

is on a voluntary basis. It is a two-year period,

either at the end of the third year or immediately before
the beginning of the fourth year, but it is on a

voluntary basis

unquestionably of Canada's greatest to consider the much

greater development of the postgraduate profession, that

is in a sense giving employment to medical students

during the summer, during their vacation?

DR. JOHNSON: When a person is in a

and in one year there has been no activity at all in



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Johnston

10210

getting general physicians to volunteer for this, and the student is not considered to be taken advantage of at all, he is not the helper at all. He is there to get instruction.

THE CHAIRMAN: Does he get any money?

DR. JOHNSTON: No.



1911
Johnston

getting general principles to volunteers for this, and
the student is not considered to be taken advantage of
at all, he is not the helper at all. He is there to
get the question.

THE IRMAN: Does he get any money?
MR. JOHNSTON: No

0
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30



1/hm 1 Johnston 10211

2
3
4 THE CHAIRMAN: The question was, is
5 the College prepared to consider that type of practice
6 whereby they would provide employment, sort of subsidized
7 education, medical education to that extent by providing
8 employment to medical students during the vacation period,
9 say, in the last two years?

10 DR. JOHNSTON: There has been no need
11 to pay any individual yet. In Norway all graduates from
12 medicine go out with a general practitioner for nine
13 months before they get their degree and they are both
14 paid for it, both the preceptee and the preceptor.

15 THE CHAIRMAN: We have heard from all
16 and sundry that these students do need money, we have
17 not heard of anybody who has ever got through on his
18 own.

19 COMMISSIONER McCUTCHEON: We have not
20 heard of anybody in Canada who can get along.

21 THE CHAIRMAN: We were wondering if
22 instead of asking the government to put up all this
23 money that some way might be found whereby the profession
24 might help itself in its recruitment program and its
25 training program?

26 DR. JOHNSTON: Are you speaking of
27 getting more medical students?

28 THE CHAIRMAN: I am just suggesting
29 if you make the conditions more attractive that it might
30 have the effect of getting more.

DR. JOHNSTON: I would agree thoroughly
with that.

COMMISSIONER FIRESTONE: Dr. Johnston,
may I turn to recommendation 5 on page 3 where you say:



THE CHAIRMAN: The question was, is the College prepared to consider that type of practice whereby they would provide employment, sort of subsidized education, medical education to that extent by providing employment to medical students during the vacation period say, in the last two years?

DR. JOHNSON: There has been no need to pay any individual yet. In Norway all graduates from medicine go out with a general practitioner for nine months before they get their degree and they are both paid for it, both the prescriber and the prescriber.

THE CHAIRMAN: We have heard from all and sundry that these students do need money, we have not heard of anybody who has ever got through on his own.

COMMISSIONER MONTGOMERY: We have not heard of anybody in Canada who can get along.

THE CHAIRMAN: We were wondering if instead of asking the government to put up all this money that some way might be found whereby the profession might help itself in its recruitment program and its training program?

DR. JOHNSON: Are you speaking of getting more medical students?

THE CHAIRMAN: I am just suggesting if you make the conditions more attractive that it might have the effect of getting more.

R. JOHNSON: I would agree thoroughly with that.

may I turn to recommendation 5 on page 3 where you say:



Johnston

10212

"The College hopes for the fullest
"support of its appeal to the Minister
"of Finance for income tax deduction
"of expenses of family doctors'
"attendance at approved refresher
"courses, necessary for the maintenance
"of their standards."

Do I understand from this recommendation
that you have already made a submission to the Minister
of Finance?

DR. JOHNSTON: We made a submission
last summer to the Minister of Finance.

COMMISSIONER FIRESTONE: Did you
present argument in support of this submission?

DR. JOHNSTON: Yes.

COMMISSIONER FIRESTONE: Could you tell
us what this argument was?

DR. JOHNSTON: Very briefly that
we contend when a doctor goes away for a refresher
course to keep himself up to date that this should not
be considered part of a capital asset, that it should
be in the nature of a repair to his knowledge. It is
on this basis that we think there is good justification
for some relief in this. We were convinced so thoroughly
that if family physicians had this relief that many
more would be attending university courses.

COMMISSIONER FIRESTONE: Are there
any precedents in this field in areas other than family
doctors to which you refer?

DR. JOHNSTON: I do not believe there are



Johnston

10213

1
2
3 and I believe that is one of the stumbling blocks to
4 this being considered. I do not like to go outside of
5 Canada but it is conceded in the United States, they
6 do get income tax relief for expenses for attending a
7 refresher course within the United States provided it
8 is not leading to a degree and, I think, provided it
9 is not any longer than a period of something like six
10 weeks.

11 COMMISSIONER FIRESTONE: And does the
12 university course apply to all medical practitioners
13 where the general practitioners are specialists?

14 DR. JOHNSTON: We are only appealing
15 for general practitioners, it does not matter whether
16 they are doctors of our college or not.

17 COMMISSIONER FIRESTONE: I understood
18 you to refer to a United States practice and I do not
19 know what that United States practice is.

20 DR. JOHNSTON: In the United States
21 this applies only to the general practitioner, as I
22 understand it, but I am not sure of that.

23 DR. HUNT: If I may say, the background
24 of why this comes up, we are the only group of doctors
25 who demand post-graduate education for the holding of
26 our certificate which is 100 hours post-graduate every
27 two years. In that case we must leave our practice
28 and attend courses at our own expense and generally this
29 is to keep our standards up.

30 COMMISSIONER FIRESTONE: Therefore,
your point is your group faces a special problem which
is not shared by others and therefore you would feel



and I believe that is one of the standing blocks to
 this being considered. I do not like to be critical of
 Canada but it is considered in the United States, they
 do not income tax relief for expenses for attending a
 postgraduate course within the United States provided it
 is not leading to a degree and, I think, provided it
 is not any longer than a period of something like six
 weeks.

COMMISSIONER: I am not sure. And does the

university course apply to all medical practitioners
 where the general practitioners are specialists?
 MR. TAYLOR: We are only specialists
 for general practitioners, it does not matter whether
 they are doctors or not.

COMMISSIONER: I am not sure. I am not sure.

you to refer to a United States practice and I do not
 know what that United States practice is.
 MR. TAYLOR: In the United States.

this applies only to the general practitioner, as I
 understand it, but I am not sure of that.

MR. TAYLOR: If I may say, the fact that

of why this comes up we are the only group of doctors
 who demand post graduate education for the holding of
 our certificate which is 100 hours post-graduate every
 two years. In that case we must have our practice
 and attend at least 100 hours of our own and generally this
 is to keep our status up.

your point is that we have a feeling of obligation
 to not stand by others and the others would not



Johnston

10214

1
2
3
4 you should be treated in accordance with recommendations
5 you have made without reference of precedent to other
6 cases?

7 DR. HUNT: That is true and it means
8 not only giving up your practice to attend, there is
9 also an attendance fee of \$50.00 or \$75.00 or \$100.00
10 when you arrive as well as your expenses otherwise.

11 COMMISSIONER FIRESTONE: Is the term
12 "family doctors" and "general practitioners" taken to
13 by synonymous?

14 DR. JOHNSTON: We are using it in that
15 sense.

16 COMMISSIONER FIRESTONE: You also say
17 in this paragraph attendance at "approved university
18 courses"; who would approve them?

19 DR. JOHNSTON: We would approve them.

20 COMMISSIONER FIRESTONE: We being?

21 DR. JOHNSTON: The College. There is
22 one other point in this I think is of real significance
23 and that is when we state it is mandatory for our
24 members to take 100 hours study every two years, we
25 have been strictly enforcing that and some hospitals
26 that have developed departments of general practitioners
27 like the Ottawa Civic has made it mandatory that the
28 general practitioner has to be a member of our College.
29 This is spreading across the country so it is part of
30 his condition of employment in a hospital that he keep
up to date. I think this is another strong argument
why we should get some relief, for instance.

THE CHAIRMAN: You say you are compelling



Johnston

10215

1
2
3 them to do this?

4 DR. JOHNSTON: That is right.

5 THE CHAIRMAN: What is the form of
6 compulsion?

7 DR. JOHNSTON: They have to submit
8 every two years a statement of the course they have
9 attended and these are assessed at the provincial level.
10 We have a group who know the type of course and they
11 are again assessed at a central level to see they are
12 somewhat uniform. It is on that basis that we would
13 consider them adequate.

14 THE CHAIRMAN: If they do not qualify
15 what happens?

16 DR. JOHNSTON: We have been enforcing
17 it strictly, we were losing about 75 members a year
18 because they cannot qualify.

19 THE CHAIRMAN: Losing membership in
20 the college?

21 DR. JOHNSTON: Yes.

22 THE CHAIRMAN: Did they still practise
23 medicine?

24 DR. JOHNSTON: Oh, this has nothing
25 to do with that, it is a voluntary organization, and,
26 as I say, more and more hospitals who are taking general
27 practitioners on the staff are making it mandatory that
28 they be members of our College.

29 COMMISSIONER FIRESTONE: In making
30 your submission to the Minister of Finance did you make
that point that your group requires as a mandatory
condition that these courses be taken?



100-100000-100000

then to the United

States, that is right.

What is the form of

organization?

They have to provide

every two years a statement of the course in the

attended and then an assessment at the technical level.

to have a group who know the type of course and then

the exam assesses at a technical level. As they are

somewhat uniform, it is on that basis that the whole

country is assessed.

What is the result of that?

What result?

in effect, we were looking at it perhaps a year

because they cannot do it.

in effect, having a membership in

the college.

What is the result?

What is the result of that?

What is the result?

What is the result of that?

as I say, it is a very good thing, and

as I say, there are some people who are doing

production on the 100,000, and making it

they are members of the college.

What is the result of that?

your attention to the 100,000, and that you take

that point that you have received as a result

condition that there is a result.



Johnston

10216

1
2
3
4 DR. JOHNSTON: Yes.

5 COMMISSIONER FIRESTONE: Did you
6 emphasize that mandatory requirement?

7 DR. JOHNSTON: Yes.

8 COMMISSIONER FIRESTONE: And notwith-
9 standing that mandatory requirement you had no action
10 taken on this request so far?

11 DR. JOHNSTON: We have had no answer
12 but it was not in the budget so I guess that is it.

13 COMMISSIONER FIRESTONE: If I may turn
14 to paragraph 6 on page 3 you say:

15 "The College hopes for an increase in
16 "the number of scholarships and bursaries
17 "available to its members for participa-
18 "tion in intensive refresher courses."

19 Where do you get such scholarships?

20 DR. JOHNSTON: We have 28 scholarships
21 to the value of \$500.00 each and they were obtained
22 from two of the pharmaceutical firms. This was not
23 done at our request because I am not permitted by my
24 regulations to ever ask for help but they offered help
25 in an educational field and we suggested they make
26 scholarships available. These are for at least a two-
27 week extension course at some hospital, they are for
28 an intensive two-week course or more.

29 COMMISSIONER FIRESTONE: To do what?

30 DR. JOHNSTON: To do intensive training.
These scholarships, we have 28 and we have about 300
applications for these each year but only 28 scholarships
to offer.



Mr. [Name],

Dear Sir:

Enclosed for you are the following:

1. A copy of the report of the

Commission on the [Topic] of the

Department of Education.

2. A copy of the report of the

Commission on the [Topic] of the

Department of Education.

3. A copy of the report of the

Commission on the [Topic] of the

Department of Education.

4. A copy of the report of the

Commission on the [Topic] of the

Department of Education.

5. A copy of the report of the

Commission on the [Topic] of the

Department of Education.

6. A copy of the report of the

Commission on the [Topic] of the

Department of Education.

7. A copy of the report of the

Commission on the [Topic] of the

Department of Education.

8. A copy of the report of the

Commission on the [Topic] of the

Department of Education.

9. A copy of the report of the

Commission on the [Topic] of the



Johnston

10217

1
2
3
4 COMMISSIONER FIRESTONE: Do you get
any scholarships from the Federal Government?

5 DR. JOHNSTON: No.

6 COMMISSIONER FIRESTONE: When you say
7 the College hopes for an increase in the number of
8 scholarships and bursaries, is this to be taken that
9 you accept any funds from the Federal Government for
10 this purpose?

11 DR. JOHNSTON: No, we have not explored
12 it with them.

13 COMMISSIONER FIRESTONE: I appreciate
14 you have not explored it but as you know, this Royal
15 Commission is here not to advise the pharmaceutical
16 industry, they will have to make their own decisions,
17 but to advise the Federal Government and I am trying to
18 understand if there is anything in this statement that
19 these scholarships are made and that this additional
20 training will be a help not only to the profession but
21 to the people who will come to them for professional
22 services and, therefore, additional bursaries be made
23 available. The question as I put it to you, is there
24 any recommendation that you feel this Commission should
make to the Federal Government to offer any assistance
in accordance with paragraph 6 of your recommendations?

25 DR. JOHNSTON: We would welcome further
26 scholarships and bursaries from any source, I think,
27 providing there were no strings attached.

28 COMMISSIONER FIRESTONE: Thank you
very much.

29 DR. BEAN: I think probably while we
30



12214

Continued

COMMISSIONER: Do you get

any scholarships from the Federal Government?

COMMISSIONER: When you are

the College has for an increase in the number of
scholarships and bursaries, as this to be taken from
you except any from the Federal Government for
this purpose?

DR. JOHNSON: No, we have not explored

it with them.

COMMISSIONER: I appreciate

you have not explored it but as you know, this level
Commission is here not to advise the pharmaceutical
industry, they will have to make their own decisions,
but to advise the Federal Government and I am trying to
understand if there is anything in this statement that
these scholars are not and that this additional
training will be a help not only to the profession but
to the people and will come to them for professional
services and, therefore, additional numbers be made
available. The question as I put it to you, is there
any recommendation that you feel the Commission should
make to the Federal Government to offer any assistance
in accordance with paragraph 6 of your recommendations?
DR. JOHNSON: We would welcome funds

scholarship and for some from any source, I think,
providing there were no other attached.

COMMISSIONER: Thank you, I have you

DR. JOHNSON: I think probably with me



Johnston

10218

would not be averse to taking them, if they were going to come into any field of scholarships, speaking personally, I would be quite happy to see them go into the under-graduate field where there is a tremendous need; there is a need here too but I think the prime need is in the under-graduates.

COMMISSIONER FIRESTONE: If the Federal Government were to consider a comprehensive scholarship plan on the graduate or under-graduate level, the graduate level including graduate courses you would feel should be included?

DR. JOHNSTON: Yes.

COMMISSIONER FIRESTONE: Thank you very much.

COMMISSIONER BALTZAN: Just one or two questions; how long does it take to become eligible in the College?

DR. JOHNSTON: A doctor can become an associate member at once after he graduates. He cannot become an active member until five years or four years later; if he has two years of internship training though we are trying to encourage them to take two years internship training rather than one.

COMMISSIONER BALTZAN: With two year training interning would you still have to wait for the two years?

DR. JOHNSTON: That is part of it.

COMMISSIONER BALTZAN: The loss of 75 members that you mentioned, is that because physicians are not able to get their vacation and the cost for going and attending these courses that you prescribe,



would not be aware of it. In fact, if they were aware
of some date and level of achievement, something
personally, I would be able to see that go into
the achievement level. When there is a response
here, there is a need to see that the person
is in the right place.

Industrial development was to consist of a comprehensive
relationship plan on the graduate or undergraduate
level, the graduate level, including graduate courses
and would be a plan of the graduate.

WILLIAM L. FLETCHER: Thank you
very much.

DR. FLETCHER: I have just one or
two questions. How long does it take to become eligible
in the field?

DR. FLETCHER: A doctor can become
an associate member at any time he wishes. He
cannot be one an associate member until five years of
four years later. He has two years of internship
and then the time he is trying to become a full member
of your relationship building, which then goes

to a full member and will have to wait for the
two years.

DR. FLETCHER: Is that the end of it?
DR. FLETCHER: Yes, that is the end of it.
In general, the relationship, as we have discussed, is
the relationship between the doctor and the patient.
And, in addition, there are other things, such as



Johnston

10219

1
2
3
4 is that the reason or what other reason is there?

5 DR. JOHNSTON: Many times we cannot
6 find a reason why they do not qualify. If it is due
7 to illness and so forth we would be charitable and give
8 him another year but some of them just do not take it
9 seriously enough. This is not easy for many doctors;
10 for instance, he is away out in an isolated area by
11 himself, it may not be easy for him to get away as
12 often as he should. We try to be reasonable and yet
13 we try to insist. To take a post-graduate study is a
14 matter of habit and we want to get the young doctors
15 in the habit because if he starts going away for the
16 refresher courses he will likely keep it up.

17 COMMISSIONER BALTZAN: Would you say
18 on the whole the accessibility to hospitals on the
19 part of many general practitioners, the tendency has
20 increased? Does that convey that impression or is there
21 still some sort of restriction? Is it increasing
22 accessibility?

23 DR. BEAN: I think the accessibility
24 is increasing tremendously across the country. There are
25 a number of general hospitals who have established
26 general practitioners and it applies to other specialties,
27 they are subject to the same rules laid down by the
28 committees as any physician which is exactly as it should
29 be. There are a few that are not particularly the larger
30 schools which have remained as closed hospitals and
where the general practitioner has been excluded. In
the rural areas there is no problem because often this
is the only place, the only doctor there and he is in



Q. Now, Mary, when we cannot

find a reason why they do not do it. If it is due to illness and so forth we would be charitable and give him another year and some of them just do not take it seriously enough. There is no way for many doctors; for instance, he is away out in an isolated area by himself, it may not be easy for him to get away as often as he should. We try to be reasonable and yet we try to insist. To make a housewife study is a matter of habit and we want to get the young doctors in the habit because if he starts going away for the rest of his life he will likely keep it up.

Q. Now, would you say

on the whole the responsibility to hospitals on the part of many general practitioners, the tendency has already been that country that is there still as a sort of restriction is it increasing

Q. Now, I think the responsibility

is increasing for the country. There are a number of general hospitals and have established general practitioners and it applies to other specialists they are subject to the same rules laid down by the committee of any kind which is exactly as it should be. I am sure that any not particularly the proper solution which has remained as closed hospitals and the general practitioner has been excluded. In the past years there is no problem because often this is the only place, the only doctor there and he is in



J Chnston

10220

1
2
3 control of the hospital. There have been, I would say,
4 within the past four or five years quite a large number
5 of hospitals across Canada that have seen fit to admit
6 general practitioners so they can take care of their
7 patients.

8 COMMISSIONER BALTZAN: With the
9 hospitals as they are today with the surgery, medicine,
10 et cetera, all the other departments and the general
11 practitioner, would you favour the applicant being on
12 active staff and being allocated to one department,
13 several departments or what departments? It is a problem
14 that has been created through this accreditation
15 requirement.
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

1933

1933

control of the hospital. There have been, I would say, within the last five years quite a large number of hospitals which have been built that have been fit to admit general practitioners so they can take care of their

COMMISSIONER: With the

hospitals as they are today with the surgery, medicine, at certain, and the other departments and the general practitioner, would you favour the applicant being on a full staff and being allocated to one department, several departments or at all departments? It is a problem that has been created through this accommodation



Johnston

10221

dpw DR. JOHNSTON: This is a problem that is being solved very nicely and is being solved very amicably between us and the Canadian Council of Hospital Accreditation and other bodies. There is no real difficulty in this. The place of a department in general practice of a hospital is not a service department. Patients are never admitted to them. It's for educational purposes and the members of that department apply for privileges the same as clinical departments, such as medicine and surgery, and are granted them according to their competence.

THE CHAIRMAN: Who judges competence?

DR. JOHNSTON: The Credentials Committee of the hospital and where there is a malfunctioning department of general practice, they will have a representative on that Committee along with other departments. It's a democratic way of assuring we have a good solution to this. A good assessment of the doctors' ability, in other words, put it. Each hospital has, in a large general hospital, has its own Credentials Committee.

COMMISSIONER BALTZAN: I am sorry, is that being accomplished fast enough, sufficient enough, to satisfy you?

DR. JOHNSTON: I wouldn't want to say fast enough, sir. I think the progress is very good. This has to be done on a local level and you have to depend upon the experience and judgment of a lot of local people.

All we can do is help them. For example, like the Ottawa Civic Hospital recently in its



...the same solved very nicely and is being solved very
...between us and the Canadian Council of Hospitals
...There is no real
...the place of a department in
...is not a service department
...to them. It is for
...of that department
...the same as clinical departments,
...and are granted then
...comparative
...the judges concerned?
...The President's Committee
...of the hospital and where there is a malfunctioning
...they will have a representative
...with other departments.
...we have a good solution
...ability, in
...in a few
...General Committee, but the President's Committee
...I am sorry, is
...sufficient though,
...to satisfy you?
...I wouldn't want to say
...the program is very good
...and you have to
...a lot of
...the
...the
...the



Johnston

10222

1
2
3 regulations wrote a requirement that any member of the
4 active staff must be either certified in a specialty
5 or a member of the College of General Practice. This
6 was done at the local level. It's the only way it can
7 be done. I don't know whether I am answering your
8 question or not, sir.

9 COMMISSIONER BALTZAN: Fine.

10 DR. JOHNSTON: We need help. Please
11 don't think that we are at all satisfied. We are not.
12 There is a great deal to be done, but this is a lot
13 that everybody has to learn. A lot of us have to learn
14 a lot of things yet.

15 COMMISSIONER STRACHAN: Mr. Chairman,
16 this may have been alluded to. Referring to Recommendation
17 No. 3, paragraph (a), it states:

18 "That a thorough review and probable
19 revision of the whole medical curriculum is a fundamental necessity,
20 keeping in mind that the general
21 physician has one of the most important
22 roles in medicine."

23 Have any representations been made by
24 your body to the proper authorities, and have you had
25 any helpful results?

26 DR. JOHNSTON: A good deal of thought
27 has gone into this. We have discussed it informally.
28 The most concrete thing we are going to do this Fall is
29 our conference on training for general practice in which
30 our own leaders will be there and we hope to have, and
expect to have, representatives from the Deans' Association,



Johnston

10223

1
2
3 from various medical schools and so forth to help us.
4 It will be a two or three-day conference on training
5 general practice.

6 Now, this is a very large question you
7 speak of. We spell this out a little further on, para-
8 graph (c) -

9 "... a thorough review and probable
10 revision of the whole medical curri-
11 culum ..."

12 We feel down in (c), where we say:

13 "There is a need for representation
14 by general practitioners on medical
15 school curriculum committees."

16 We feel that some of our men have a
17 great deal to contribute in this field; that are called
18 upon to do so.

19 Some medical schools have had represen-
20 tatives from general practitioners on them for years.
21 Others haven't had them at all. We would like to see
22 this as a general policy. Perhaps some of my colleagues
23 have something to say.

24 There is one study that interests me
25 and I think we can bear this out, that the more post-
26 graduate training a general practitioner has taken, the
27 more questioning he has in his mind as to what his educa-
28 tional experience has been.

29 In other words, the more training he
30 gets - there has been a study on this, and I think it is
true, the more - the men who have taken the most study,
post-graduate study, are the ones that tend to be the



Johnston

10224

most critical of their training for general practice.
It may have some significance.

We are critical of it in the sense
that we would like to be helpful. We are very grateful
what our teachers did for us.

DR. BEAN: I think the one thing we
should like to get across is we feel that the standard
of general practice in Canada, Mr. Chairman, has been
very admirable. It is not the idea that the College
wishes to create something good out of something which
was bad, but rather part of the self-discipline under
which we exercise in hospital staffs, which Dr. Baltzan
has alluded to.

We want to establish this as the role
in general practice and we feel now that we are approaching
the stage where, perhaps, the problem should be reviewed
and that we are getting, just as the Royal College at
one time got, people who are saying "Doctor, how do I
become a specialist?" "How do I get training in this
particular facet of it which I want to go in?" and the
College laid down a method of recognized training which
would be acceptable to them.

In other words, the best method of
doing it. This is the phase that we are approaching in
the College of General Practice at the present time.

The conference to which Dr. Johnston
alluded is really the first step to sitting down with
the educators and practising physicians in an attempt
to work out just where we go from here.

We have, in addition to that, been



Bean

10225

1
2
3 carrying on, have just completed under our sponsorship
4 a five-year survey of general practice in two provinces in
5 which some federal assistance was received in
6 order to carry this on.

7 THE CHAIRMAN: When will Dr. Klutz'
8 report be available?

9 DR. JOHNSTON: It's in the hands of the
10 printer now and will be available in November.

11 DR. BEAN: And this is all part of the
12 program.

13 COMMISSIONER STRACHAN: You have stated,
14 sir, that your object is to encourage young physicians
15 and I have no desire to criticize your constitution or
16 your rules and regulations; nevertheless, you state
17 that a graduate must have been out five years before
18 he can become an active member of your Association.

19 Is this a recognition of the fact that
20 he might have got into a rut, or of the fact that he
21 has, at the end of five years, realized that he is no
22 longer a mature physician?

23 DR. JOHNSTON: As I stated, he can
24 become an associate member at once. We feel to make him
25 an active member we should know a little bit, what sort
26 of a practising doctor he is or can be.

27 When we set five years, we wanted two
28 years internship, and three years after that. We will
29 be able then to assess something of his character.
30 Whether he was interested in post-graduate studies, for
instance.

COMMISSIONER STRACHAN: Well, supposing



Johnston

10226

1
2
3 he has been fortunate enough to take a couple of courses
4 during these first five years. Would he get any credit
5 for that at all?

6 DR. JOHNSTON: Yes.

7 COMMISSIONER STRACHAN: Could he
8 assume active membership earlier then?

9 DR. JOHNSTON: No. There is this five-
10 year period which is mandatory. No exceptions made.
11 Four years if he has taken two years internship.

12 COMMISSIONER STRACHAN: You were
13 speaking of the man who finds it difficult to leave his
14 locality. Is any leeway permitted there if he has some
15 problems going within a certain time to take a course?

16 DR. JOHNSTON: Oh yes, if a man says
17 "I cannot go every two years, I can make it in three" -
18 this has happened sometimes. "I will go away for a
19 month", and this sounds reasonable. He is serious
20 about it. Certainly we will entertain that.

21 What we want to know particularly is
22 he really interested in these courses? What is his
23 philosophy about it?

24 COMMISSIONER McCUTCHEON: Dr. Johnston,
25 just one point, and you may have covered it. If you
26 did cover it, I missed it. Referring again to paragraph
27 9 on page 3, it seems to me that you pointed out to the
28 Chairman that there were two facets to this one area;
29 the ability of the practitioner to follow his patient
30 into the hospital to treat him and the other was member-
ship in the hospital staff.

You refer particularly, or gave us one



Johnston

10227

example; the matter of the Ottawa Civic Hospital where, as I understand, you say there are members of the College of General Practice now on the active staff of the Ottawa Civic Hospital. My question is this: does this affect the status of the other general practitioners in the area and any general practitioner in the Ottawa area to follow his patient into the Ottawa Civic Hospital?

DR. JOHNSTON: This varies greatly. I cannot answer that at the Ottawa Civic. Many of these hospitals, a general physician can still treat his patient there. Some can't. Some can, in some of these hospitals, but we want more than that. We want him on the active staff.

COMMISSIONER McCUTCHEON: You want him to be able to go in surely, first?

DR. JOHNSTON: I beg your pardon?

COMMISSIONER McCUTCHEON: You want to be able to follow your patient in as well as being on the active staff?

DR. JOHNSTON: That is right. Well, if he is on the active staff, it follows.

COMMISSIONER McCUTCHEON: Oh, I agree, but you visualize all the general practitioners in the Toronto area being on the active staff of some hospital in the area?

DR. JOHNSTON: Oh, no.

COMMISSIONER McCUTCHEON: Does that mean there will always be a group of general practitioners who cannot follow their patients into the hospital?

DR. JOHNSTON: You are dividing this.



Johnston

10228

I will take a hospital in Toronto with 84 general physicians. Now, they have created this and there are about 40 of these who are called senior men or other categories, and they can be on the active staff. The rest are courtesy, are junior. There is a ladder for the man to climb as he goes up.



Johnston

10229

3/dpw COMMISSIONER McCUTCHEON: I was trying to get this straight in my mind.

DR. JOHNSTON: And the general physicians may be able to treat their patients. There are privileges of getting beds depending on whether you are courtesy or active; this varies from hospital to hospital.

COMMISSIONER McCUTCHEON: The mere fact that the general practitioner being on the active staff of the hospital automatically gives him the right to admit patients and therefore to follow his patients through. Is the general practice in the City of Toronto - leave out the teaching hospitals, but to what extent, if any, can I follow my patient into the hospital? Do I have to be appointed to the courtesy staff?

DR. BEAN: Firstly, you would have to do the same as any physician. You would have to come on the staff of the hospital, being a general practitioner or surgeon. You come in dependent upon the regulations of the hospital. You are taken on, generally, as an associate, doctor-sponsored. Some physician says, "I am prepared to sponsor this man and oversee his work for a period of one year." At the end of this year depending on the regulations of the hospital, generally he has to present a series of cases to the staff, and then he becomes a member of the junior active staff and then he gradually works his way up.

Even within the departmentalized hospitals, when we are bringing in a man, even if he is an eminently qualified surgeon, even a cardiac surgeon, the first year he is on as an associate member of the staff



Bean

10230

and his work is overseen by, the term we use, is a jury of his peers.

COMMISSIONER McCUTCHEON: Supposing I don't find a sponsor, my application is turned down. - In other words, are you seeking a situation where every general practitioner will have access to a hospital?

DR. BEAN: Yes, sir.

COMMISSIONER McCUTCHEON: Irrespective of his qualifications in the eyes of his peers?

DR. BEAN: No, no.

DR. JOHNSTON: For instance, in a hospital of 84 general physicians, they are all in the department of general practice, but they are in different categories. Some have courtesy standards, some are junior and some are senior.

COMMISSIONER McCUTCHEON: There might be people who wouldn't be on at all?

DR. JOHNSTON: Yes.

COMMISSIONER VAN WART: I have only one observation to make; that is, your financial statement, No.3, I see your organization is being supported by the modern concept of deficit financing. Is that true?

DR. JOHNSTON: We went in the last couple of years - we were running on a deficit of about \$1,500 each year. I don't think that is very serious deficit financing. We are trying to get out of it. I have a little bit of philosophy on that; if I spend the money I think the members will find some way of meeting the debt.

COMMISSIONER McCUTCHEON: It sounds like



Johnston

10231

the Minister of Finance.

DR. JOHNSTON: Provided the budgets are good.

THE CHAIRMAN: Dr. Johnston, you are really patient with us. Perhaps I might impose on you for another minute or two. Naturally we are concerned with adequate and good medical services in all parts of Canada. What does the College of General Practice see for itself in providing medical services in the outlying sparsely-populated areas of Canada because, I suppose, we must recognize that it is the general practitioner who must necessarily go to the frontiers.

DR. JOHNSTON: Of course, we have given some thought to this. We have no policy on this, but we are aware that there is a mal-distribution of doctors in certain areas.

THE CHAIRMAN: How we can correct that situation? Have you any recommendations to offer in that regard?

DR. JOHNSTON: One is No. 2: the provision of better conditions for practice in understaffed areas would lead to a better distribution of doctors. These conditions will have to include laboratory, x-ray and hospital facilities and provision of consultant services - get these closer to them.

I almost hesitate to open up something else but I feel that somehow we could get more doctors, more medical students from the rural and small areas. There was a study in the United States in which they found that the higher the proportion of students that



Johnston

10232

came from urban areas, the higher the proportion of those that stayed in the urban areas. I may be shot down for bringing this up.

THE CHAIRMAN: We will give you such protection as we can.

DR. JOHNSTON: I think if something could be done through scholarships and so forth to assist doctors in the smaller places in the country, for instance, like Dr. Dymond announced not long ago: he is making available \$20,000 this year to be given to 20 medical students, pay them \$1,000 for that year. The plan is that if they stay they will get another \$1,000 loan if they need it, and so forth. That would mean more than \$40,000 next year because they would be starting another 20. He announced this plan. Something like this could be done because such a small percentage of our medical students are coming from the rural areas and small towns.

The last survey I know of, the one by CAMSI about 10 years ago in which it was found of all the medical students of that year 12% only came from the rural areas, which made up 35% of the population.

THE CHAIRMAN: Having done that, how is that going to get them back, merely because you say some will filter back because they came from the rural areas originally?

DR. JOHNSTON: I would think it would be of assistance.

THE CHAIRMAN: I mean, is there any condition on these loans?



Johnston

10233

1
2
3
4 DR. JOHNSTON: I would go further,
5 I would say through scholarships I think we can place
6 these men.

7 THE CHAIRMAN: Have you got any notions
8 of the extent to which general practice might or should
9 be subsidized in the outlying areas?

10 DR. BEAN: I think, Mr. Chairman, that
11 the principle as enunciated here to ask a physician to
12 go out in the Prairies...

13 THE CHAIRMAN: Let us go up in the
14 Rocks in Ontario, leave these beautiful Prairies alone.
15 We are having troubles enough.

16 DR. BEAN: It is a matter of the
17 provision of facilities in which the physician can work.
18 That will be the first thing that is conditional upon,
19 I believe, in getting the local people building the
20 hospitals with a view to attracting a physician there
21 so they have the laboratory and x-ray facilities avail-
22 able to them.

23 While we mention the provision of
24 consultant services this may not be so much the idea of
25 the consultant going in as the patient being flown out.

26 THE CHAIRMAN: We can't reasonably look
27 to building hospitals for every doctor, talking now of
28 a doctor going into the pioneer area or one of these
29 isolated areas.

30 DR. JOHNSTON: We don't have to go very
far away from home. In the County of Lennox in Addington
they have one doctor to 2,400 people and in the County
of Oxford, one doctor for 980 people. I don't know the



Johnston

10234

answer at all, how we can get more to go into Lennox and Addington.

THE CHAIRMAN: I was putting it to you; have you any ideas of whether there should be some subsidy available to provide the services in those areas where there is a definite under-service?

DR. JOHNSTON: We have never considered it, sir.

THE CHAIRMAN: Never considered it.

DR. JOHNSTON: We haven't, honestly. We are trying to - this is not an answer to your question, sir, but we are trying...

THE CHAIRMAN: I don't want to press you, but you represent the general practitioners of Canada. You are the people who are going to have to give this kind of service, are you not?

DR. JOHNSTON: Yes.

THE CHAIRMAN: Is it fair to say, if you want to think it over it is all right, we might ask you for some ideas of how the general practitioners might be induced, what the carrot is that will take them out into these areas that are now not serviced because we have got to cling to the general concept of making more services available to all parts of Canada?

DR. JOHNSTON: We would be pleased to seriously think about this further if you wish.

THE CHAIRMAN: I am asking you if you will, and if you will communicate any ideas you have on that subject to us within the next three or four months.

DR. JOHNSTON: Thank you. We would be



Johnston

10235

pleased to.

THE CHAIRMAN: Thank you very much.

We are very grateful to you. It is not unfair for us to say the responsibility which rests on the shoulders of the general practitioners in Canada is a very heavy one and we are most glad to have your views, to know your ideas on the program of medicine in Canada for the next 20 or 30 years. Thank you very much, gentlemen.

DR. BEAN: Before we leave I would like to thank you very much on behalf of the College of General Practice of Canada for the opportunity of presenting this brief for your very courteous attentiveness.

THE CHAIRMAN: We will resume at 9.30 tomorrow morning in the Sir Daniel Wilson Residence in the Howard Ferguson Auditorium.

--- Adjournment.

